

January 1, 1983

Ontario Health Insurance Plan

Schedule of Benefits

PHYSICIAN SERVICES



Ontario

Ministry of
Health

OHIP
SCHEDULE OF BENEFITS
JANUARY 1 1983

ERRATA

PAGE CODE

76	X162 P. Spec. \$14.60 NOT \$14.50
	X193 T. Spec. \$11.20 NOT \$11.40
	X165 P. Spec. \$ 7.30 NOT \$ 7.10
81	J325 P. Col. \$ 6.40 NOT \$ 6.30
	J034 P. Col. \$ 9.20 NOT \$ 8.90
	J311 P. Col. \$ 7.40 NOT \$ 7.15
	J307 P. Col. \$ 7.40 NOT \$ 7.15
	J306 P. Col. \$ 6.40 NOT \$ 6.30
90	G286 "with timed pulse" NOT "with times pulse"
109	P042 \$361.40 NOT \$361.00
	P007 \$ 35.40 NOT \$ 35.90
131	R295 \$191.30 NOT \$193.30
144	R445 \$111.60 NOT \$111.69
146	R457 \$255.10 NOT \$255.19
214	N160 \$265.70 NOT \$265.75
220	N187 \$648.40 NOT \$648.50
232	E959 \$ 67.30 NOT \$ 67.80
L23	L827 \$ 3.50 NOT \$ 4.30
	L828 \$ 4.40 NOT \$ 6.30

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PREAMBLE

A. General

1. The rates listed in this Schedule of Benefits are the maximum payments which can be made by the Ontario Health Insurance Plan.

2. Insured medical services are limited to the services which are medically necessary, which are listed in this Schedule of Benefits and which are not specifically excluded by legislation or regulation (see Appendix A for a list of specific exclusions).

3. Additions, deletions or other modifications of the Schedule of Benefits require recommendation by the Ontario Health Insurance Plan. Such recommendations are made in consultation with the Ontario Medical Association.

4. This Schedule is a public document and frank discussion with patients regarding the listed rates is recommended.

5. Claims for services which are not listed in the Schedule or which are listed as N.A.B. (not a benefit) or which are excluded as benefits by legislation or regulation should not be submitted to the Plan. Such services may be charged directly to patients or others requesting them.

6. The principles governing proper professional charges are incorporated in the Regulations (Medicine) of the Health Disciplines Act.

7. Each physician who participates in the care of a patient is entitled to compensation commensurate with the services he renders.

8. Whenever possible, the physician should acquaint the patient or person financially responsible with his obligations to those concerned with his care. This is particularly important where supportive or concurrent care is rendered or when a consultation and/or procedure are being arranged.

9. Each physician participating in the care of a patient should render to the patient, or to the financially responsible party, an itemized statement of charges for professional services.

10. Each physician participating in the care of a patient should, on request, send a receipt to the patient for all payments made by him.

11. If fees are collected by an organized group, the name of the physician rendering the service should be clearly shown on the bill or claim card.

12. Documentation: whenever a physician examines or treats a patient, an appropriate record of this service must be made and such record must be in keeping with section 28 of Regulation 577/75 of the Health Disciplines Act, 1974 (see Appendix B).

13. Claims may be submitted for services which a patient receives from the team of staff man, resident, intern and clerk in a teaching unit, provided that the conditions as set out hereunder apply.

On October 10, 1972, the Minister of Health confirmed that the joint recommendations of the College and the O.M.A. governing the charging of fees for services provided by interns and residents in clinical teaching units are acceptable to the Ministry of Health. In his letter the Minister made it very clear that he is looking to the College and the Medical Schools to en-

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sure that the ethical rules governing these billing procedures are followed meticulously in all cases.

It has been carefully explained that the responsible staff man must be present in the clinical teaching unit at the time the services are rendered and must be identified to the patient at the earliest possible moment. No fees are to be charged for services given by the intern or resident prior to this identification taking place. The following rules are now in effect:—

When patient care is rendered in a clinical teaching unit or other setting for clinical teaching by a health care team, the physician responsible shall be personally identified to the patient. His relationship to the team shall be defined by the clinical teaching unit Director and his role must be known to the patient and other members of the team. He shall assume full responsibility for the appropriateness and the quality of the services rendered.

Specific regulations must vary with the service and form of care being delivered:—

- (a) In order to claim for physical procedures being carried out by an intern or resident, the responsible staff man must be in the clinical teaching unit and immediately available to intervene.
- (b) In psychotherapy where the presence of the staff man would distort the psychotherapy milieu, it is appropriate for the staff man to claim for psychotherapy when a record of the interview is carefully reviewed with the resident and the procedure thus supervised. However, the time charged by the staff man may not exceed the total time spent by him in both such interview review and in direct supervision.
- (c) In other departments or services, the staff man should only claim for visits on the days when actual supervision of that patient's care takes place through the presence of that staff man in the clinical teaching unit on that day. This, of course, involves a physical visit to the patient and/or a chart review with detailed discussion with the other member(s) of the health team.
- (d) In those situations where on a regular basis a staff member might supervise concurrently multiple procedures or services through the use of other members of the team, the total claims made by the staff man shall not exceed the amount that the staff man might make in the absence of the other members of the team.

Any claim rendered should be in the name of the responsible staff man.

14. Charges for missed appointments are not benefits of O.H.I.P.

B. Terms and Definitions

Call or Visit: is the service by a physician to or on behalf of a patient for assessment and/or treatment.

1. Consultations:

- (a) A consultation refers to the situation where a physician, in light of his professional knowledge of the patient, requests the opinion of another physician competent to give advice in this field, because of the complexity, obscurity or seriousness of the case or because another opinion is requested by the patient or an authorized person acting on his behalf. The consultant is obliged to perform a general or specific assessment, review the laboratory and/or other data and submit his findings, opinions and recommendations in writing to the referring physician.
- (b) If a consultant is requested by a physician on duty in the emergency department to

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- see a patient in consultation, the consultant may claim a consultation for this service. If the consultant is requested to perform this same service by a resident or intern, the consultant may claim a general or specific assessment according to his specialty.
- (c) For laboratory and procedural benefits connected with consultations, see listings of Laboratory Medicine and Diagnostic and Therapeutic Procedures.
 - (d) A consultation is not to be claimed as such when:
 - (i) The patient presents himself to a consultant's office without prior knowledge of the primary physician. The sending of a report to the primary physician under these circumstances does not justify a claim for a consultation.
 - (ii) The primary physician is not asked for professional advice but is simply asked by the patient for the name of a specialist in a particular field and the patient seeks out the specialist himself.
 - (e) A limited consultation may involve all of the components of a full consultation but is less demanding, and in terms of time, normally requires substantially less of the physician's time than the full consultation.
 - (f) A diagnostic radiology consultation applies when radiographs made elsewhere are referred to a radiologist for his written opinion or when a radiologist is required to make a special visit at Night (5.00 p.m. to 7.00 a.m.), Saturdays, Sundays and Holidays to consult on the advisability of performing a diagnostic radiological procedure which eventually is not done. A consultation does not apply when the radiographs referred to above are used for comparison purposes with radiographs made in the consultant's facilities.
 - (g) A diagnostic pathology consultation applies when tissue slides are referred to a second pathologist for a written opinion. It includes secretarial or other assistance but does not apply when the tissue slides referred to above are used for comparison with tissue slides done in the consultant's facilities. When a diagnostic pathology consultation fee is claimed L821 may not also be claimed.
 - (h) A pathology consultation or repeat consultation applies when a pathologist is requested to examine a patient and provide a written opinion.
 - (i) A diagnostic nuclear medicine consultation applies when nuclear medicine studies are referred to a nuclear medicine specialist for a written opinion or when the nuclear medicine physician is required to make a special visit at night (5.00 p.m. to 7.00 a.m.), Saturday, Sunday or Holiday to consult on the advisability of performing a nuclear medicine procedure which eventually is not done. A consultation does not apply when procedures done elsewhere are used for comparison purposes with nuclear medicine studies made in the consultant's facilities.
 - (j) A nuclear medicine consultation or repeat consultation applies when a nuclear medicine specialist is requested to examine a patient and provide a written opinion, all of which takes a greater amount of time and effort than a nuclear medicine study would normally require. It may be done in conjunction with a nuclear medicine study but if so, the lesser professional benefit (P_2) rather than the greater benefit (P_1) should be claimed in addition to the technical (T) benefit.
 - (k) Some nuclear medicine specialists have other specialist qualifications which allow

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them to claim other consultation benefits (e.g., internal medicine). A nuclear medicine consultation or repeat consultation may be claimed in lieu of another consultation (e.g., internal medicine) but would not be combined with a claim for such a consultation by the same consultant.

- (l) A prenatal consultation by a paediatrician applies when a physician considers a fetus of greater than 20 weeks gestation to be at risk or in jeopardy by reason of continuation of pregnancy in the presence of maternal and/or foetal distress, and requests the opinion of a paediatrician competent to give advice in this field. The paediatrician shall perform a general or specific assessment, review laboratory and other data and submit his findings and recommendations in writing to the referring physician. Such a consultation does not preclude the paediatrician from a postnatal consultation on the infant.
- (m) OHIP benefits for consultations normally are limited to one consultation per year, per patient, by any one physician. However, if the same patient is referred to the same consultant a second time within the year with a clearly defined unrelated diagnosis, one additional consultation may be claimed per year.

2. **Repeat Consultation:** requires all of the criteria of a full consultation and implies interval care by the primary physician. The situation in which the consultant requests the patient to return for a later examination is not a repeat consultation.

3. **General Assessment:** shall comprise a full history, an enquiry into, and an examination of all parts or systems (and may include a detailed examination of one or more parts or systems), an appropriate record, and advice to the patient.*

OHIP benefits for general assessments normally are limited to one per year per patient by any one physician. However, if the same patient presents again within the year to the same physician with a clearly defined new diagnosis, one additional general assessment may be claimed per year. In the case of a patient who proceeds normally to hospital, the admitting physician may claim one additional general assessment per year provided 90 days have elapsed since the last general assessment rendered (anywhere) to that patient by the admitting physician. If the patient doesn't qualify for a general assessment by the admitting physician, he may claim a general re-assessment.

4. **General Re-Assessment:** shall comprise the same services as a general assessment except that the history need not include all the detail already obtained in the original general assessment.*

OHIP benefits for general re-assessments, except for hospital admission re-assessments, are limited to two per year, per patient, by any one physician.

5. **Specific Assessment:** shall comprise a full history of the presenting complaint, enquiry concerning, and detailed examination of the affected part, region or system, as needed to make a diagnosis and/or exclude disease and/or assess function, an appropriate record, and advice to the patient.*

Physicians qualified in two specialties (EENT for example) may only claim for one visit, eg: a consultation (if referred) or a specific assessment (if non-referred), if both systems are

*For laboratory and other investigation performed in conjunction with a consultation or visit, see Diagnostic and Therapeutic Procedures and Laboratory Medicine.

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examined during the same visit. However, two consultations or two specific assessments, etc. may be claimed if both systems are examined, each on a separate visit.

OHIP benefits for specific assessments normally are limited to one per year, per patient, by any one physician. However, if the same patient presents again within the year to the same physician with a clearly defined new diagnosis, one additional specific assessment may be claimed per year.

6. Specific Re-Assessment: shall comprise a full relevant history and a comprehensive physical examination of one or more systems but not requiring an evaluation of the patient as a whole.*

In the surgical specialties, anaesthesia and dermatology, a specific re-assessment applies when a repeat specific assessment is required and carried out on a patient within a year's time for the same condition and with the same diagnosis; it shall comprise the same services as a specific assessment except that the history need not include all of the detail already obtained in the original specific assessment. A specific re-assessment is not to be claimed for treating a minor problem or for visits required solely for assessing the response to a treatment of a previously diagnosed condition unless an additional clinical assessment is required and performed.

In the medical specialties, a specific re-assessment applies in the management and assessment of the progress of serious chronic disease. It is not to be claimed for treating a minor problem or for visits required solely for assessing the response to treatment of a previously diagnosed condition unless an additional clinical assessment is required and performed.

7. Intermediate Assessment: is a more extensive assessment than a minor assessment and shall comprise a history of the presenting complaint(s), enquiry concerning and examination of the affected part(s), region(s), or system(s) or emotional disorder as needed to make a diagnosis, exclude disease and/or assess function, an appropriate record, and advice to the patient.*

8. Multiple Systems Assessment: shall comprise a detailed history and examination of more than one system, part or region, an appropriate record and advice to the patient.

9. Minor Assessment: is a brief assessment comprising the necessary history, examination of the affected part or region, an appropriate record and advice to the patient. It also applies to a subsequent visit solely for assessing the response to treatment of a previously diagnosed condition when the necessary examination and/or assessment reveals that no additional clinical assessment is required and none is performed.*

10. Psychotherapy: is any form of treatment for mental illness, behavioural maladaptations, and/or other problems that are assumed to be of an emotional nature, in which a physician deliberately establishes a professional relationship with a patient for the purposes of removing, modifying or retarding existing symptoms or attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development. Accordingly, therefore, a psychotherapeutic procedure may be claimed if a half hour or major part thereof has been spent by a physician in such treatment of the patient. Psychotherapy may not be claimed by more than one physician for the same patient at the same time.

Please note that the College of Physicians and Surgeons of Ontario has stated that "in or-

*For laboratory and other investigation performed in conjunction with a consultation or visit, see Diagnostic and Therapeutic Procedures and Laboratory Medicine.

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der to qualify for a psychotherapy claim, a minimum of twenty minutes must be spent with the patient. When psychotherapy extends beyond thirty minutes, the major part (16 minutes) of the next half hour must be spent with the patient to qualify for an additional half hour fee. Similarly, after an hour of psychotherapy, the major part (16 minutes) of the next half hour must be spent to qualify for an additional half hour fee and so on." (Medical Review Committee Bulletin, Volume 3, Number 1.)

11. **Counseling:** as distinct from psychotherapy, counseling is that activity in which the physician engages in an educational dialogue with the patient(s) on an individual or group basis wherein the goal of the physician and patient(s) is to become aware of the patient(s) problems or situation and of modalities for prevention and/or treatment. Counseling is not intended for ongoing treatment or a substitute for a patient assessment, and it must be rendered personally by the attending physician.

Advice given during a visit for patient assessment and relative to that assessment (see definitions) is included in the assessment benefit and does not qualify for "counseling".

12. **Genetic Counseling:** includes interviewing the appropriate family members, the collection and assessment of adequate clinical and genetic data to make a diagnosis, construct a pedigree, and assess the risks to persons seeking advice. It includes imparting this information and the various alternatives to the appropriate family members in such a way that they can make informed decisions about dealing with the genetic problem.

13. Examinations of Well Persons:

(a) **Age:** (unless otherwise specified)

Newborn — up to 10 days of age.

Infant — up to 2 years

Child — up to and including 15 years

Adolescent — up to and including 17 years

Adult — 18 years or over.

- (b) **Newborn Care:** is the routine care of a well baby up to ten days of age and should include a complete physical examination of the baby and necessary instructions to the mother. The service shall involve at least two visits, and normally may not be claimed for the same patient by more than one physician.

When a well baby is transferred to another hospital (because of the mother's state of health, for example) claims for newborn care by a physician at each hospital may be appropriate.

- (c) **Low Birth Weight Care:** is the care of a baby weighing less than 2.5 kilograms at birth.
- (d) **Well Baby Care:** the periodic visits of a well baby during the first two years of life involving complete examination with necessary weight and measurements and instructions to the parent(s) regarding health care.
- (e) **Annual Health or Annual Physical Examination** (Including Primary and Secondary School Examinations): shall comprise all the elements of a general assessment as it pertains to an individual who presents and reveals no apparent physical or mental illness. O.H.I.P. benefits for any one physician are limited to one Annual Health Ex-

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amination per patient per year after the second birthdate. To qualify for O.H.I.P. benefits, an Annual Health Examination normally must be requested by the patient rather than a third party. Under Regulation 323 of The Health Insurance Act, 1972, examinations for the purpose of "legal requirements or proceedings" are excluded from coverage. However, it is recognized that an Annual Health Examination will satisfy some or all of the requirements for examinations required by statute but excluded by the above mentioned Regulation. In such instances and where a prior claim for an Annual Health Examination has not been submitted to the Plan in the previous twelve months for that patient, it would be appropriate to submit a claim to OHIP for this service. The OHIP benefit in these cases covers the Annual Health Examination only and not any charges peculiar to the legal requirements, such as charges for the completion of forms.

Other Terms, Definitions and Guidelines

14. **Coding:** This schedule lists a code number opposite most items. Items which are not coded are identified either as U.V.C. or N.C.

U.V.C. — use visit codes applicable to the pertinent service and specialty.

N.C. — no code applicable. This service is not a benefit (N.A.B.) of O.H.I.P., and may be charged directly to patients.

For the surgery portion of this schedule, physicians submitting claims in coded form should add to the code numbers, the suffix A if they perform the procedure, the suffix B if they have assisted at the surgery or the suffix C if they have administered the anaesthetic.

For those diagnostic and/or therapeutic procedures which have the technical and professional components listed separately, but under the same code, the suffix A should be added to the code numbers when both components are being claimed, the suffix B when only the technical component is being claimed, or the suffix C when only the professional component is being claimed.

Where separate codes are listed for the technical or the professional components, the suffix A should be used.

For diagnostic radiology, only one code is listed for each service, even though some of these services may be provided by non-certified radiologists. The code for services rendered by non-certified radiologists should be obtained by increasing the first digit in the listed codes by 5. Thus, for example, the code for the service listed as X001 but rendered by a non-certified radiologist would be X501 plus the appropriate suffix.

15. **General Listings:** include the basic listings for consultations, assessments and other visits wherever they are rendered, except for non-emergency services to hospital or long-term care institution in-patients and for care rendered by a physician on duty in an emergency department. These latter services are listed separately in the Schedule.

A visit rendered to a patient in a rest home, lodge, detoxification centre, half-way house, or other institution not covered elsewhere in the Schedule, should be claimed under the General Listings.

16. **Non-Emergency Hospital In-Patient Services:** include the listings for consultations and other visits to registered bed patients.

(a) The general assessment, general re-assessment, specific assessment or specific re-as-

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assessment rendered in conjunction with a patient's admission to hospital is considered to be the hospital "admission assessment". Such assessments may not be claimed more than once during a hospital admission even if a patient's care subsequently is transferred to another physician. Moreover, such assessments may not be claimed by a consultant who also is claiming a consultation in conjunction with the patient's admission to hospital. Such consultation by the admitting physician serves as the admission history and examination.

- (b) Subsequent routine visits should be claimed as "subsequent visits (minor assessments)". Claims for daily hospital visits must not be made unless a physician actually visits the patient each day. Prior to the weekly and monthly limitations that apply after a patient has been in hospital for 5 weeks (6 weeks for paediatricians), payments for hospital visits generally are limited to one per patient per day. For acute illnesses or exacerbation of original illness requiring additional visits before or after 5 weeks of hospitalization, claims for extra visits should be made on an independent consideration basis.
- (c) When a patient in hospital is referred by one physician to another, the second physician will not be limited by the Subsequent Hospital Visit formula for the number of hospital visits already rendered by the first physician. In other words, the second physician is entitled to claim for his visits up to five weeks just as if the patient was being attended to in hospital for the first time. However, if the patient is transferred to the care of another physician, the Subsequent Hospital Visit formula would apply just as it would if only one physician was involved in the care.
- (d) When a physician already is in the hospital and is asked to assess one of his own in-patients on a non-emergent or emergent basis, the subsequent hospital visit listings apply. However, if he is asked to assess another physician's patient on an emergent basis, the General Listings should be used.

17. Emergency Department — Physician on Duty Services: include the listings for minor and multiple systems assessment and the specific premiums applicable to **the services rendered by the physician on duty.** A physician on duty in the Emergency Department regardless of his specialty should submit claims under these listings. A physician who is not on duty in the Emergency Department should use the General Listings when seeing patients in the emergency or out-patient departments. See Appendix C for further guidelines to claiming for services rendered in the Emergency Department.

18. Long-Term Institutional Care: includes the listings for consultations, assessments and other visits to patients in chronic care hospitals, convalescent hospitals, nursing homes and other institutions in which such patients are covered by extended care legislation.

Admission assessments to long term care institutions are classified as —

Type 1 — applies when the admitting physician has not performed a consultation, general assessment or general re-assessment prior to admission and when he carries out a general assessment (on admission) and provides a report for the medical record.

Type 2 — applies when the admitting physician has performed a consultation, general assessment or general re-assessment prior to admission, makes an initial visit and records an admission note describing the condition of the patient following admission.

When a physician already is in the institution and is asked to assess one of his own in-patients on a non-emergent or an emergent basis, the subsequent visit listings apply. However, if

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he is asked to assess another physician's patient on an emergency basis, the General Listings should be used.

19. **Visit for Procedure:** when the sole reason for an office visit is the performance of a certain procedure, the listed benefit for the procedure will apply. (See Diagnostic and Therapeutic Procedures Preamble for exceptions.) When procedures are carried out in the office, emergency or outpatient department on an elective basis, a special visit should not be claimed in addition to the procedural fee.

When procedure(s) are carried out by a physician's employee(s) under the direct supervision of the physician, the usual claims may be made for procedure(s) which are generally and historically accepted as those which may be carried out by the nurse or other medical assistant in the employ of the physician. "Procedures" in this context do not include such services as assessments, consultations, psychotherapy, counselling, etc. Direct supervision requires that during the procedure the physician be physically present in the office or clinic at which the service is rendered.** While this does not preclude the physician from being otherwise occupied he should be in personal attendance on enough occasions to ensure that procedures are being performed competently and he must at all times be available immediately to approve, modify or otherwise intervene in a procedure as required in the best interests of the patient.

For physiotherapy procedures performed under direct physician's supervision as detailed above, see Code G467 on Page 104.

20. Premiums:

(a) **Special visit fees chargeable in addition to benefits for services listed under consultations and visits, critical care and injections or infusions.**

- (i) A special visit is one which is initiated by the patient or his representative which requires a physician to travel from one location to another to see a patient(s). That is, when the physician is not already in the office, hospital, institution, patient's home, etc. and is called to make a special trip there to attend a patient, a "special visit" premium may be claimed. The premium(s) for a special visit to the office only applies outside of normal office hours but does apply whether or not the office is in the physician's home.
- (ii) The special visit premiums apply only to emergent or non-elective calls and do not apply to non-referred or transferred obstetrics. The premiums do not apply to visits on regular rounds, and admission assessments of patients who have been admitted to hospital, etc. on an elective basis do not qualify as "special visits", regardless of the time performed.
- (iii) If an institution has arranged to have quarters in the same or in a proximal building in order that a physician will be available to make visits to the institution, particularly at night, these are not considered to be "special visits" to the institution.

When services are rendered on an emergency basis at a site other than listed in this schedule (e.g. roadside, ski slope, etc), the special visit premiums are applicable.

**Some procedures may not require the physical presence of a physician for adequate supervision. Exceptions to this requirement of direct supervision may be made upon recommendation of the Ontario Medical Association and the College of Physicians and Surgeons of Ontario.

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If a physician is called to pronounce a patient dead, a minor assessment may be claimed along with the appropriate surcharge for the special visit.

- (iv) An emergency call with sacrifice of office hours may be claimed in a situation where the demands of the patient and/or the physician's interpretation of the patient's condition is such that the physician responds immediately at the sacrifice of regular office hours.
- (v) A special visit at night or on a Saturday, Sunday or holiday may be claimed when non-elective or emergent calls are made between the hours of 5.00 pm and 7:00 am or are received and made on Saturdays, Sundays and Holidays. "Holidays" are defined for the purpose of this schedule as New Year's Day, Good Friday, Easter Monday, Victoria Day, Dominion Day, Civic Holiday, Labour Day, Thanksgiving, Remembrance Day, Christmas Day and Boxing Day. If any of these holidays fall on a Saturday or Sunday, at the physician's discretion either the Friday before or the Monday following will be recognized as the holiday.
- (vi) Only one special visit premium (daytime; sacrifice of office hours; or nights, Saturdays, Sundays and Holidays) may be claimed for the same patient, same visit, **and do not apply to non-referred or transferred obstetrics.**
- (vii) The Home Visit premiums apply to emergent or non-elective assessments which are initiated by a call from the patient or his representative. It is recognized, however, that a home visit occasionally may be required because of the patient's medical condition even though the physician has not been called specifically for that visit. For such "elective home visits", the daytime special visit premium B990 is applicable in addition to the appropriate assessment under the General Listings. The Special Visit premiums applicable to nights, Saturdays, Sundays, Holidays or sacrifice of office hours, however, are not appropriate, regardless of the time of the visit.
- (viii) Normally, the "additional patient" premiums are not applicable unless the additional patient himself qualifies for a special visit. Patients who drop in to the office or Emergency Department while the physician is there for reasons other than rendering a special visit at that time do not qualify for any of the special visit premiums. However, extra patients during a home visit or those who drop in to the office or Emergency Department while the physician is there rendering a special visit to another patient also qualify for the "additional patient" premiums if an assessment is rendered.

Extra in-patients seen during a special visit to a hospital or other institution do not qualify for the "additional patient" premiums unless the physician has been asked specifically to see these extra patients as well. (See also paragraph 16(d) above.)

Patients seen during "office hours" held at night or on Saturdays, Sundays or Holidays do not qualify for any of the special visit premiums.

Special Visit Benefits:—(applicable in addition to benefits for services listed under "Consultations and Visits" and "Critical Care") K992, C992, K993, C993 also are applicable to assistant and/or anaesthetist at emergency surgery.

- (ix) Daytime (Monday to Friday) special visit to Emergency Department or O.P.D.
 - K990** First patient assessed add \$10.60
 - K991** For each additional patient requiring a special visit and assessed during same special visit, **add 20% to assessment fee.**

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- (x) Emergency call with sacrifice of office hours —
K992 first patient assessed add \$21.25
K993 for each additional patient requiring a special visit and assessed during same special visit **add 20% to assessment fee.**
- (xi) Evenings, Saturdays, Sundays, Holidays (5:00 p.m. to midnight) —
K994 first patient assessed add \$21.25
K995 for each additional patient requiring a special visit and assessed during same special visit **add 20% to assessment fee.**
 Nights (midnight to 7:00 a.m.)
K996 First patient assessed add \$31.90
K997 For each additional patient requiring a special visit and seen during the same special visit, add 30% to the assessment fee.

Where no consultation or visit fee is applicable charge 20% of the Intermediate Assessment fee (A007, \$2.90) when claiming for K991, K993 or K995, & 30% of the Intermediate Assessment fee (A007, \$4.35) when claiming K997. And also add to Critical Care or injection or infusion fees chargeable to additional patients (excluding Respiratory Care and Neonatal Intensive Care).

- (xii) Special visit to office —
 The above benefits apply, but the prefix "A" should be substituted for the prefix "K" in the code (e.g. A990 instead of K990).
- (xiii) Special visit to patient's home —
 The above benefits apply, but the prefix "B" should be substituted for the prefix "K" in the code (e.g. B992 instead of K992).
- (xiv) Special visit to hospital in-patient —
 The above benefits apply, but the prefix "C" should be substituted for the prefix "K" in the code (e.g. C992 instead of K992).
- (xv) Special visit to long-term care institution —
 The above benefits apply, but the prefix "W" should be substituted for the prefix "K" in the code (e.g. W992 instead of K992).
- (xvi) Special visit to any setting not listed above, or emergency services at the roadside, ski slope, etc.
 The above benefits apply, but the prefix "Q" should be substituted for the prefix "K" in the code (e.g. Q994 instead of K994).
- (xvii) Non Elective Surgical Procedures or Clinical Procedures Associated with Diagnostic Radiological Examination: — when such procedures including Caesarean sections, the surgical management of ectopic pregnancies, fractures or dislocations or **major invasive procedures contained in the list of Diagnostic and Therapeutic Procedures or elective procedures which because of intervening emergency procedure(s) commence after 5:00 p.m. and before midnight or on Saturdays, Sundays and Holidays, increase the procedural fee(s) by 20% (**E409**). For all other obstetrical procedures e.g. deliveries occurring on Saturdays, Sundays and Holidays, increase the procedural fee(s) by 20% (**E409**). When the foregoing procedures commence after midnight and before 7:00 a.m. any night during the week, increase the procedural fee(s) by 50% (**E410**).

These premiums are not chargeable in addition to the obstetrical procedural fee(s) if labour is induced by medical and/or surgical means by the same physician. However, a forewater A.R.M. or oxytocin augmentation of labour carried out on a patient in desultory labour does not constitute induction.

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These premiums are not chargeable (during or after a "shift") by casualty officers or other physicians who have elected or are required to be physically and continuously present in the Emergency Department or environs for an arranged designated period of time.

****Major Invasive Procedures are considered to be the following:**

G254	G269	G287	G294	G324	G332	G399	R841	R853
G264	G270	G288	G295	G327	G347	G411	R843	R854
G265	G275	G290	G302	G328	G348	G412	R849	Z804
G266	G277	G291	G303	G329	G349	G418	R850	Z805
G267	G280	G292	G304	G330	G380	R833	R851	
G268	G285	G293	G323	G331	G398	R840	R852	

E409 or E410 may not be claimed for procedures which mainly involve the interpretation of test results and are not applicable to assessments or consultations. Neither are they applicable to physicians on duty in the emergency department nor to procedures listed in the Diagnostic Radiology, Nuclear Medicine or Diagnostic Ultrasound sections of the Schedule.

- (xviii) Non-elective Nuclear Medicine, Diagnostic Radiology, **Laboratory Medicine** or Diagnostic Ultrasound Examinations.

C109 For special visits, **evening** (5:00 p.m. to midnight) or before midnight, Saturdays, Sundays or Holidays to perform examinations listed in the Nuclear Medicine, Diagnostic Radiology, **Laboratory Medicine** or Diagnostic Ultrasound sections of the Schedule, a premium of \$21.25 may be added to the benefit for the first examination performed on any one patient or may be claimed alone if it is decided that the procedure is not medically indicated and a consultation is not rendered.

C110 For such special visits commencing between midnight and 7:00 a.m., the applicable premium is \$31.90.

- (xix) Assistants' services —

E400B For cases commencing after 5:00 p.m. and before midnight or before midnight on Saturdays, Sundays and Holidays, the total benefit for assistant units (basic and time) is increased by 30%.

E401B For cases commencing after midnight and before 7:00 a.m., the total benefit for assistant units is increased by 50%.

- (xx) Anaesthetists' services —

E400C For cases commencing after 5:00 p.m. and before midnight or before midnight on Saturdays, Sundays and Holidays, the total benefit for anaesthetic units (basic and time) is increased by 30%.

E401C For cases commencing after midnight and before 7:00 a.m., the total benefit for anaesthetic units is increased by 50%.

- (b) **Special Care Unit (e.g. I.C.U. or C.C.U.) —**

C101 For each patient seen on visit to I.C.U. or C.C.U. (excluding supportive care), add \$4.60 to charges for all such visits.

Note: Where visit is not chargeable,

e.g. post operative care by surgeon, claim only C101

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21. **Detention:** benefits may be applicable for detention when under very exceptional circumstances a physician is required to spend considerable extra time with a patient. Such extra time must be **spent in active treatment of the patient**, and it must be to the exclusion of all other work.

Claims for detention must be substantiated by an explanation on the claim card or in an accompanying letter, and should be made on an "I.C." basis according to the following guidelines:

After twenty minutes if the physician spends more than this amount of time providing a minor or intermediate assessment or subsequent hospital visit;

After forty minutes if the physician spends more than this amount of time providing a specific or general re-assessment or multiple systems assessment or certification of mental illness;

After one hour if the physician spends more than this amount of time providing a consultation, limited consultation, repeat consultation, prenatal consultation, specific or general assessment.

Detention is not meant to apply to procedures nor to obstetrical care and does not include time waiting for X-rays, lab reports, the operating room or for the patient to arrive for assessment or treatment.

K001 Detention, per quarter hour or part thereof \$12.75

K101 Detention, while in attendance with patient(s)
in ambulance, per quarter hour or part thereof \$21.25

Note: K101 is not applicable to attendance in a vehicle other than an Ambulance.

22. **Independent Consideration** — "I.C.": independent consideration will be given by O.H.I.P. for those items in the Schedule of Benefits which are listed as I.C.. Claims rendered under this heading must include a specific charge along with a detailed explanation of that charge. Where pertinent, an operative report is very helpful in rendering independent consideration. It also is helpful if I.C. claims include a comparison of the scope and difficulty of the procedure with other specific procedures listed in the Schedule.

23. **Transferral and Referral:**

(a) A referral takes place when one physician requests for his patient the services of another. The services of the latter may consist of:

(i) an opinion (i.e. a consultation)

(ii) diagnostic tests or procedures (e.g. skin test, biopsy, etc.)

Note: In such cases the referring physician continues to treat the case himself.

(iii) treatment (surgical or medical).

The referring physician's O.H.I.P. registration number must be included on the claim submission.

(b) A transferral, as distinguished from a referral, takes place where the responsibility for the care of the patient is completely transferred permanently or temporarily, from one physician to another in the same field or specialty (e.g. where the first physician is leaving temporarily on holidays and unable to continue to treat the case). The physician to whom the patient is transferred should be regarded as substituting for the other physician and is not entitled to claim for a consultation. Physicians who

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are substituting for other physicians should consider that patients of the latter have been temporarily transferred (not referred) to their care. Where the care of the patient involves a benefit containing several components such as surgery the physicians may consider the surgical benefit a team benefit and decide among themselves how each is to be compensated; traditionally physicians in these circumstances have reciprocated by exchanges of coverage for each other. When physicians routinely or frequently substitute for each other providing hospital visits to registered bed patients in active treatment hospitals, e.g. weekend coverage or daily rounds by various members of a group, the most responsible physician may claim for all the visits.

24. Most Responsible Physician: is the attending physician who is primarily responsible for the day to day care of the patient in hospital. In cases of unusual severity where the consultant assumes the role of the most responsible physician, the consultant may claim on a per visit basis and the family physician may claim supportive care. Where the family physician remains the most responsible physician and requests only a consultation, the family physician may claim on a per visit basis and the consultant may claim for a consultation only.

25. Concurrent Care: when the family physician remains the most responsible physician but because of the seriousness or complexity of the condition, requests continued directive care by a consultant, the family physician may claim on a per visit basis. The consultant also may claim on a per visit basis, not to exceed four such claims during the first week of **concurrent care** and not to exceed two such claims each week thereafter while the patient's condition remains serious — this arrangement being agreeable to both physicians.

26. Multidisciplinary Care: applies when the complexity of the medical condition requires the services of several physicians in different disciplines. In such cases, each physician should render a separate claim on a per visit basis. This does not refer to a situation where a single benefit for a team of physicians is listed in the Schedule.

27. Supportive Care: is the care rendered in hospital by the referring physician, who is not actively treating the case (e.g. writing orders), to a patient under the care of another physician, at the desire of the patient or family, for purposes of liaison or reassurance. The physician may claim for this care on a per visit basis, not to exceed four such claims during the first week of **supportive care** and not to exceed two such claims each week thereafter. If medical complications develop or are present in the post-operative period which require active management by the referring physician, claims for hospital medical care should be rendered, not supportive post-operative care.

28. Specialist: a specialist shall be defined (for purposes of application in the case of any given service within this Schedule) as one who holds a certificate from the Royal College of Physicians and Surgeons of Canada in the specialty which normally is considered to encompass the service in question.

A specialist rendering services outside of his specialty should use the codes and tariffs listed in the General Practice section of the Schedule

29. Differential Benefits:

- (a) Where only one benefit is listed, it shall apply to any physician rendering the service, regardless of specialty.

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- (b) Consultation and visit benefit listings under the heading of Family Practice and Practice in general may be claimed by other branches of medicine if the listings do not appear elsewhere in the Schedule.
- (c) Specialists in paediatrics who practice allergy may claim specialist rates for their allergy services regardless of the age of their patients.

30. Referring Physician's Services:

- (a) For the services rendered prior to an operation, the referring physician should claim on a "fee-for-service basis", for example:
 - (i) Home, Office or Hospital Visits as rendered.
 - (ii) In addition to (i) above, in acute cases, benefits may be claimed for detention if applicable and appropriate (refer to paragraph 21, above).
- (b) (i) For services rendered as an assistant during the operation, the referring physician should claim in accordance with paragraph 32, below.
- (ii) In cases in which the referring physician is required to be present in the interest of the patient but does not actually assist at the surgical procedure, he should claim a hospital visit for this service.
- (c) For the services rendered after the operation, the referring physician may claim on the basis of supportive care as outlined in the Schedule.

31. Pre-dental Assessment:

A physician, regardless of specialty, who is required to examine a patient in preparation for dental surgery under general anaesthesia may claim \$18.40 when he has seen the patient in the previous twelve months for a general assessment or \$27.60 if he has not seen the patient within the previous twelve months for a general assessment. If the examining physician also administers the anaesthetic only \$18.40 may be claimed in addition to the anaesthetic benefit, for the history and examination required by the hospital on admission (this is an exception to paragraph 33(a)).

32. Assistants' Services:

- (a) Time units are computed by allowing one unit (\$6.52) for each 15 minutes or part thereof of time (up to two hours) spent by the assistant. Time units for assistants' services for periods in excess of two hours per case are computed by allowing two units for each 15 minutes or part thereof. Time for purposes of these calculations includes scrub time and time spent in the operating room. If claims are being made in coded form (see Preamble, part B, paragraph 14), the suffix B should be added to the code for the procedure.
- (b) The basic units should be listed separately from the time units on the claim card. Benefits for assistants' services are determined by multiplying the listed basic units and the time units by \$6.52. For cases commencing after 5:00 p.m. and before midnight or before midnight on Saturdays, Sundays and Holidays, the total benefit for assistant units (basic and time) is increased by 30% (E400B). For cases commencing after midnight and before 7:00 a.m., the total benefit for assistant units is increased by 50% (E401B).
- (c) When multiple or bilateral surgical procedures are done during the same anaesthetic,

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the assistant's benefits shall be based on the basic units for the major procedure plus time. When bilateral procedures or surgical revisions are carried out at separate times with separate anaesthetics, the assistant shall be entitled to receive full assistant's benefits for each procedure.

- (d) In surgical procedures requiring more than one assistant, benefits for the second assistant shall be computed on the same basis as for the first assistant.
- (e) When a surgeon requires an assistant at a procedure for which no assistant's units are listed, the assistant may calculate the total benefits applicable by taking the number of basic units used by the anaesthetist, adding his time units and multiplying the total number of units by \$6.52. (See also (f) below.)
- (f) When assistants at surgery claim for procedures for which no assistants' units have actually been listed in the Schedule, the assistants should support their claims with letters of explanation as to why their attendance was required.
- (g) Where the attendance of a physician is requested by the patient's other medical attendants for the sole purpose of monitoring or special supportive care, and when the physician is in constant attendance, the benefits shall be based upon 3 units plus time (E003B).
- (h) When an anaesthetic has begun and the operation is cancelled prior to commencement of surgery, the assistant who has scrubbed but is not required to do more, should claim 3 basic units plus time units (E006B). If the operation is cancelled after surgery has commenced, the procedural basic unit plus time units will apply. If the procedure is cancelled prior to the induction of anaesthesia and the assistant is scrubbed, a subsequent hospital visit only may be claimed.

33. Anaesthetists' Services:

- (a) Benefits for anaesthetists' services are for all types of anaesthesia. The rates listed are for professional services, including pre-anaesthetic evaluation and post-anaesthetic follow-up and all immediate supportive measures, and does not include the cost of materials used. If an anaesthetist is asked by a physician to see a registered bed patient in consultation more than 36 hours prior to the administration of an anaesthetic, he may claim for a consultation as well as for rendering the anaesthetic. **(This consultation is not a substitute for the pre-anaesthetic evaluation.)** If an anaesthetist examines a patient prior to surgery and the surgery is cancelled prior to the induction of anaesthesia, he may claim a subsequent hospital visit for this service. When an anaesthetic has begun and the operation is cancelled due to a complication prior to the commencement of surgery, the anaesthetist should claim 4 basic units plus time (E006C). If the operation is cancelled after surgery has commenced, the procedural basic units plus time units will apply.
- (b) Basic units are listed for most procedures and include the value of all anaesthetic services except the actual time spent administering the anaesthesia, any modifying factors, or unusual detention with the patient (see paragraph 33(k, l), below).
- (c) Except during maintenance of continuous conduction anaesthesia (G247 pg 100,

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P015 pg 109), time units are computed by allowing one unit for each 15 minutes or part thereof of anaesthesia time (up to two hours). Following the first two hours of anaesthesia, time units for periods in excess of two hours are computed by allowing two units for each 15 minutes or part thereof. Anaesthesia time begins when the anaesthetist is first in attendance with the patient for the purposes of creating the anaesthetic state and ends when he is no longer in personal attendance (when the patient may be safely placed under customary post-operative supervision).

- (d) Time units and listed basic units should be indicated separately on the claim card. Benefits for anaesthetists' services are determined by multiplying the basic and the time units by \$7.37 for certified anaesthetists and \$6.80 for non-certified anaesthetists. For cases commencing after 5:00 p.m. and before midnight or before midnight on Saturdays, Sundays and Holidays, the total benefit for anaesthetic units (basic and time) is increased by 30% (E400C). For cases commencing after midnight and before 7:00 a.m., the total benefit for anaesthetic units is increased by 50% (E401C).

If claims are being made in coded form (see Preamble, part B, paragraph 14) the suffix C should be added to the code for the procedure.

- (e) In special cases where the anaesthetic services of more than one anaesthetist are deemed necessary in the interest of the patient the benefits shall be increased by 50% of that computed for the procedure; each anaesthetist to be entitled to one half of the total benefit.
- (f) When multiple or bilateral surgical procedures are done during the same anaesthetic, the anaesthetic benefits shall be based upon the basic units for the major procedure plus time. When bilateral procedures or surgical revisions are carried out at separate times with separate anaesthetics, the anaesthetist shall be entitled to receive full anaesthetic benefits for each procedure.
- (g) In procedures where no units are listed or with I.C., the basic units will be based upon those listed for a comparable procedure considering region and modifying conditions or techniques.
- (h) When a pump with or without an oxygenator and with or without hypothermia is employed in conjunction with an anaesthetic, the anaesthetic "Basic" will be 28 units; this replaces the listed basic units for the procedure. To compensate for variations in anaesthetic practice, special respiratory intensive care or detention for the purpose of intensive treatment of other types may be claimed separately under the appropriate headings.
- (i) An additional 10 units may be claimed when, in association with anaesthesia, "controlled hypotension" is carried out using any technique to deliberately lower and maintain the mean blood pressure at least 25% below the range or normal for that patient. The extra 10 units may be claimed under code E004C.
- (j) When unusual detention with the patient before or after anaesthesia is essential for the safety and welfare of such patient, the necessary time will be valued on the same basis as indicated for the anaesthetic time.
- (k) For detention not associated with anaesthesia detention rates and criteria apply (see paragraph 21 above).

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- (l) When the attendance of the anaesthetist is requested by the patient's other medical attendants for the purpose of monitoring or special supportive care, and when the anaesthetist is in constant attendance the benefits shall be based upon 3 units plus time. If claims are coded, the code is **E003C**.
- (m) No additional claim should be made for introducing a catheter for continuous conduction anaesthesia, i.e. above the basic of 5 units plus maintenance units to a maximum of 6 units plus the number of time units required for the obstetrical delivery.
- (n) When a physician administers an anaesthetic and/or other medication prior to or during a procedure(s) and also performs a procedure(s) on the same patient, he should claim for the procedure(s) only. **However, when a physician administers a pudendal, femoral, intercostal, sciatic, ilioinguinal or iliohypogastric block in addition to performing a procedure, he may charge \$7.10 (G224) in addition to the fee for the procedure.**
- (o) When hypothermia is used by the anaesthetist in procedures not specifically identified as requiring hypothermia, the basic value is 25 units. This basic value replaces the basic value listed in the Schedule for the procedure. When the basic value claimed is 25 units, the anaesthetic service may be claimed under code **E002C**.
- (p) When one anaesthetist starts a procedure and is replaced by another part way through a surgical procedure or delivery, the first anaesthetist should claim the appropriate basic units plus time units and the second anaesthetist may claim for time units only. The second anaesthetist should use code **E005C** for such time units except in the case of continuous conduction anaesthesia for which code G247 or code P015 (plus E100C pertain (see also paragraphs 33(c) and 33(n), above), E005C qualifies for the surcharge E400C or E401C only if the case originally started within the time stated under paragraph 33(e) above. Each anaesthetist should state on his claim card which part of the anaesthetic is being claimed and the time begun and completed.
- (q) General anaesthesia for the purposes of this Schedule includes all forms of anaesthesia except local infiltration.

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APPENDIX A

Sections 49 and 49a of Ontario Regulation 323/72 made under the Health Insurance Act, 1972.

"(1) The following services are not insured services under the Plan:

- Except where medically required, surgery for cosmetic purposes.
- Expenses for travelling time or mileage.
- Testimony in a court, preparation of records, reports, certificates or communications.
- Advice by telephone.
- Any service or examination for the purpose of,
 - (a) an application for insurance or under a requirement for keeping insurance in force;
 - (b) an application for admission to or continuance at or in a school, college, university, camp, association, club, group or program;
 - (c) employment or the continuance of employment or pursuant to the request of an employer or other person in authority;
- Group examinations, immunizations or inoculations.
- Any service or examination rendered by a physician for screening, survey or research purposes.
- Services rendered by a physician pursuant to an arrangement for rendering services.
 - (a) to the employees of an employer;
 - (b) to members of an association; or
 - (c) at a camp to the campers thereof.
- Laboratory services, except,
 - (a) laboratory services prescribed in section 48a, and
 - (b) Laboratory services carried out by a physician for the exclusive purpose of diagnosing or treating his own patients in the course of his medical practice.
- Special appliances.
- Clinical pathology, except when authorized by a physician and performed.
 - (a) by a laboratory mentioned in clause a or clause b of subsection 1 of section 48a; or
 - (b) by or under the direction of any other person authorized by law.
- All procedures of acupuncture.

PREAMBLE

APPENDIX A — Cont'd

(2) The following services rendered by physicians shall be deemed not to be insured services for the purposes of the Act:

- Anaesthetic services rendered in connection with a dental procedure rendered by a dentist except where the dental procedure is performed in a hospital.
- Pre-adoption examination and evaluation for C. A. S.
- Other scan (approved but not currently listed).
- Preparation of special antigens or anti-serums.
- Special investigations.
- Dermatoglyphics.
- Group psychotherapy — seventh to ninth hour per day.
- Psychotherapy — interviews with other paramedical organizations or others on behalf of a patient.
- Orthoptics.
- Contact lens fitting, except for any of the following conditions:
 - (a) Aphakia, monocular and binocular;
 - (b) High Myopia, greater than nine diopters;
 - (c) Irregular astigmatism (post-corneal grafting or corneal scarring resulting from disease states);
 - (d) Keratoconus.
- Non-referred mammography or thermography.
- The use of EDTA in the treatment of atherosclerosis.
- HCG treatment for obesity.
- General assessment for nicotine addiction or obesity where treatment is to be by acupuncture or ear pins.

49a. The following service rendered by a physician shall be deemed not to be an insured service in respect of an insured person who is eighteen years of age or over:

1. Otoplasty for correction of "outstanding ears."

49(b)-(1) The following services rendered outside of Ontario by physicians shall be deemed not to be insured services in respect of insured persons who are under the age of sixteen years:

1. Ligation, cauterization or removal of vas deferens—uni or bilateral (vasectomy).
2. Hysterectomy or ligation, cauterization or removal of fallopian tubes—uni or bilateral by abdominal or vaginal approach, including laparoscopy, culdoscopy, or hysteroscopy—for sterilization (any method).

PREAMBLE

APPENDIX A — Cont'd

(2) All services rendered outside of Ontario by hospitals in connection with the services specified in subsection 1 shall be deemed not to be insured services in respect of insured persons who are under the age of sixteen years.

(3) Subsections 1 and 2 do not apply where the surgeon or the attending physician believes that the surgical operation is medically necessary for the protection of the physical health of the insured person.

49(c)-(2) Any service or examination for the purpose of legal requirements or proceedings, other than an examination rendered by a psychiatrist, who is not a member of the medical staff of a psychiatric facility in which a patient is detained, for the purpose of clause 31a(4)(b) of the *Mental Health Act*.

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APPENDIX B

Section 28 of Regulation 577/75 of the Health Disciplines Act, 1974.

"28—(1) A member shall,

- (a) keep a legibly written record in respect of each patient of the member setting out,
 - (i) the name and address of the patient,
 - (ii) each date that the member sees the patient,
 - (iii) a history of the patient,
 - (iv) particulars of each physical examination of the patient by the member,
 - (v) investigations ordered by the member and the results of the investigations,
 - (vi) each diagnosis made by the member respecting the patient, and
 - (vii) each treatment prescribed by the member for the patient;
 - (b) keep a day book, daily diary or appointment record setting out the name of each patient seen or treated or in respect of whom a professional service is rendered by the member.
- (2) A member shall keep the records required under subsection 1 in a systematic manner and shall retain each record for a period of six years after the date of the last entry in the record or until the member ceases to engage in the practice of medicine, whichever first occurs.
- (3) A member shall make records kept pursuant to subsection 1 and books, records, documents and things relevant thereto available at reasonable hours for inspection by a person appointed by the Registrar pursuant to section 64 of the Act, a member appointed by the Registrar for the purpose of peer review or a person appointed as an inspector under subsection 1 of section 43 of the Health Insurance Act, 1972.

PREAMBLE

APPENDIX C

"EMERGENCY DEPARTMENT" CLAIMS

PHYSICIAN ON DUTY

The listings under the heading "Emergency Department—Physician on Duty" are meant to apply only to those circumstances wherein either casualty officers or other physicians **have elected** or are required to be physically and continuously present in the Emergency Department or **environs** for an arranged designated period of time.

When the Physician on Duty is required or **elects** to remain at the hospital, the special call surcharge will not apply. Use the "Emergency Department—Physician on Duty" listings for all physicians regardless of specialty.

When a 'casualty officer' is required to make a special visit to the Emergency Department prior to or after his regular arranged designated period of time on duty, he may claim the appropriate benefit under the General Listings plus the applicable special visit premium for the first patient assessed; all subsequent patients assessed during this visit to the hospital should be claimed under the Emergency Department—Physician on Duty listings.

When a physician is on duty in the Emergency Department, sees a patient and admits the patient to hospital, this physician may claim a minor or multiple systems assessment depending upon the service initially provided. Either the patient's attending physician or the emergency department physician (but not both) may render and claim the hospital "admission assessment". If the emergency department physician instead of the attending physician provides the admission general assessment, he may claim a general re-assessment (C004) as well as the initial assessment provided that both services are rendered separately.

SPECIAL VISIT TO EMERGENCY OR O.P.D.

Consultation

1. Consultation, patient not admitted:
The benefit for the consultation (or repeat consultation) plus the appropriate special visit surcharge (K99-) may be claimed.
2. Consultation, patient admitted:
 - (a) The benefit for the consultation (or repeat consultation) plus the appropriate special visit surcharge (K99-) followed by hospital visits (if rendered) may be claimed. However, if the consultant also is the "most responsible physician", he may not also claim a hospital in-patient consultation, repeat consultation, general or specific assessment, general or specific reassessment since the initial consultation rendered in the emergency department serves as the admission assessment.
 - (b) If the consultant is not also the most responsible physician, the latter may claim the appropriate admission assessment.

PREAMBLE

Assessment:

1. **Assessment, patient not admitted —**
The benefit for the assessment (or re-assessment) plus the appropriate special visit surcharge (K99-) may be claimed.
2. **General/specific assessment plus patient admission —**
The benefit for the general or specific assessment plus the appropriate special visit surcharge (K99-) followed by hospital visits may be claimed. However, the admitting physician may not also claim a hospital in-patient general/specific assessment or reassessment since the initial general/specific assessment rendered in the emergency department serves as the admission.
3. **Minor/intermediate assessment plus patient admission —**
The benefit for the minor or intermediate assessment plus the appropriate special visit surcharge (K99-) may be claimed. In addition, the admitting physician may claim for a hospital in-patient general or specific reassessment if rendered.

Procedure:

Except for procedures for which the listed benefits specifically include the associated consultation or other assessment, claims may be made for both the procedure and the assessment.

Note:

If a physician has an office in the hospital and is called to assess a patient in the Emergency Department or O.P.D., the special visit premiums do not apply.

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APPENDIX D

1. Surgery to alleviate significant physical symptoms or to restore or improve function to any area altered by disease, trauma or congenital deformity normally is a benefit under The Ontario Health Insurance Plan. Surgery solely to alter or restore appearance is not a benefit of OHIP except under the circumstances as listed in the following policy.
 - recommended by a Mental Health Facility (as designated by The Mental Hospitals Act) or equivalent, or
 - recommended by a Correctional Institution, or
 - essential in order to obtain employment as documented by the attending physician and either by a Canada Manpower Employment Centre or by an employer with regard to a specific job, or
 - performed on a patient who is less than 18 years of age and the defect is in area of the body which normally and usually would not be clothed.
3. In establishing this policy, it has been recognized that
 - peer acceptance in our society often is influenced disproportionately by the facies,
 - children are especially susceptible to emotional trauma caused by physical appearances,
 - some procedures traditionally have been accepted as benefits of Health Insurance Plans in spite of the obvious cosmetic nature of these procedures.
4. Surgery to revise or remove features of physical appearance which are familial in nature is not a benefit of OHIP.
5. Within the context of this policy, the word "disease" does not include the normal sequelae of aging. Surgery to alter changes in appearance caused by aging is not a benefit of OHIP.
6. Within the context of this policy, the word "trauma" includes trauma due to treatment such as surgery, radiation, etc.
7. The phrase "reasonable period of convalescence" admittedly is imprecise, but it does not seem reasonable to set a definite time interval of convalescence following each procedure. Independent consideration will be given to the questionable cases.
8. Authorization from OHIP is not required for all surgery to alter appearance. It is required only for those categories of procedures for which some cases may not be a benefit under OHIP policy.

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Surface Pathology

1. Trauma Scars

(a) Neck or Face

- Includes ears and non-hair bearing areas of the scalp.
- Repair of all such scars is a benefit of OHIP.
- Repair procedures will depend upon the lesion but may include excision, revision, dermabrasion, etc. Rhytidectomy procedures to remove scar prominence, however, are not a benefit of OHIP.
- OHIP authorization for repair of such scars is not required but manual assessment of the claims will be necessary to ensure that the most appropriate procedure codes are used.

(b) Scars in other Anatomical Areas

- Repair of scars which interfere with function or which are significantly symptomatic (pain, local irritation, etc.) is a benefit of OHIP.
- Scars with no significant symptoms or functional interference
 - (i) Repair is a benefit if such repair is part of a pre-planned post-traumatic (including post-surgical) staged process. OHIP notification must be included as part of the planning process.
 - (ii) Other post-traumatic scar revision is not a benefit of OHIP.
- OHIP authorization is required for all scar repair procedures in areas other than the face or neck.

2. Keloids

(a) Head or Neck

- The repair of all such keloids is a benefit of OHIP.
- Repair procedures may include excision and/or injection.
- Although no pre-authorization is needed, claims for excision of keloids are assessed manually to ensure that the most appropriate code is used.

(b) Excision of keloids in other areas

- Not a benefit of OHIP unless significantly symptomatic or there is functional impairment.
- OHIP authorization is required.

3. Tattoos

(a) Face or Neck

- Excision or destruction of all such tattoos is a benefit of OHIP.
- Authorization is not required but adjudication of repair procedures will be identical to that for scars in these areas.

(b) Other Anatomical Areas

- Excision or destruction of concentration camp or P.O.W. tattoos is a benefit of OHIP. Otherwise, normally not a benefit of OHIP.

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4. **Benign lesions such as naevi, keratoses, spider naevi, papillomata, neurofibromata**
 - (a) **Face or Neck**
 - Excision or destruction of these lesions is a benefit of OHIP.
 - Authorization is not required.
 - (b) **Other Anatomical Areas**
 - Normally not a benefit of OHIP if removed for alteration of appearance, only, rather than for medical necessity or because of clinical suspicion or evidence of malignancy.
 - Removal of very large lesions in patients less than 18 years of age is a benefit of OHIP.
 - Authorization is not required but a statement of the reason for removal must accompany the claim.
5. **Hair Loss**
 - (a) **Head or Neck**
 - (i) **Patients less than 18 years of age**
 - Repair is a benefit for non-hereditary etiologies.
 - Authorization is not required. However, if it is possible that a planned staged procedure will extend beyond the age limit, pre-authorization should be obtained, since it will be necessary after the 18th birthday.
 - (ii) **Post-traumatic**
 - Repair to the area of traumatic hair loss is a benefit of OHIP only if carried out within a reasonable period of convalescence.
 - OHIP authorization is required.
 - (iii) **Other Etiology**
 - Not a benefit of OHIP.
 - (iv) **Usual repair procedures may include skin shifts or flaps, skin grafts, or hair plugs.**
 - (b) **Other Anatomical Areas**
 - Not a benefit of OHIP.
6. **Epilation of Hair**
 - (a) **Face**
 - This procedure is a benefit of OHIP only for those patients with documented endocrine abnormality or drug-induced hirsutism.
 - (b) **Other Anatomical Areas**
 - Not a benefit of OHIP.
 - (c) — OHIP authorization is required.

PREAMBLE

7. Redundant Skin

- (a) Excision of redundant skin for elimination of wrinkles, etc. is not a benefit of OHIP.
- (b) Blepharoplasty is not a benefit of OHIP unless there is documented evidence of medical necessity such as visual field defect caused by the redundant eyelid skin.
- (c) OHIP authorization is required.

Sub-Surface Pathology

1. Congenital deformities

(a) Head or Neck

- Repair is a benefit of OHIP except for:
 - surgery to revise or remove features which are familial in nature.
 - surgery to correct "outstanding ears" in patients who are eighteen years of age or over.
- Authorization is not required but manual assessment of the claims will be necessary to ensure that the most appropriate procedural codes are used.

(b) Other Anatomical Areas

- Normally not a benefit of OHIP if surgery is for alteration of appearance only.

2. Post-Traumatic Deformities

- Reconstructive procedures are a benefit at the acute stage; within a reasonable period of convalescence; or if part of a pre-planned staged process of repair.
- Repair of procedures may include bone revision, tissue shifts and grafts, prosthesis implantation, etc.
- OHIP authorization is required for repairs beyond the acute stage.

3. Deformities resulting from local disease

(such as loss or distortion of bone, muscle, connective tissue, adipose tissue, etc.)

(a) Head or Neck

- Reconstructive procedures for significant abnormalities are a benefit at the acute stage; during a chronic disease process; within a reasonable period of convalescence; or if part of a planned staged process of repair initiated during one of these periods.
- Repair procedures normally could include tissue grafts, flaps or shifts, bone revision, prosthesis insertion, etc.
- Face lifts, modified face lifts, brow lifts, etc. are not a benefit of the Plan if skin, only, is involved in the procedure. However, a repair such as ptosis repair or face lift with underlying slings is a benefit of OHIP if the procedure is to correct significant deformity following stroke, cancer, VIIth nerve palsy, etc.
- OHIP authorization is required for repair of deformities resulting from local disease.

PREAMBLE

(b) Other Anatomical Areas

- Not a benefit of OHIP if the correction is for appearance, only.

4. **Breast Surgery**

(a) Augmentation Mammoplasty

- This procedure is a benefit of OHIP unilaterally or bilaterally for a female patient with breast aplasia.
- It is an OHIP benefit unilaterally for a female patient with a severely hypoplastic breast when the other breast is not also hypoplastic.
- A "balancing" augmentation mammoplasty may be allowed on an independent consideration basis for correction of unilateral hypoplasia when performed in association with approved contralateral reduction mammoplasty.
- The correct code for the repair procedure is R112.
- OHIP authorization is required.

(b) Post-Mastectomy Reconstruction

- Unilateral or bilateral breast reconstruction is a benefit of OHIP when the procedure is subsequent to, as listed in the Schedule of Benefits, total or partial mastectomy (including wedge resection) or prophylactic mastectomy.
- Authorization is not required but all claims are manually assessed to determine the benefit appropriate to the procedure rendered.

(c) Reduction Mammoplasty

- **Reduction Mammoplasty** is a benefit for female patients only, **where** there is significant associated symptomatology such as intertrigo, neck or back pain or shoulder grooving. Ptosis and/or size are not sufficient grounds for OHIP coverage of reduction mammoplasty
- **Unilateral Reduction Mammoplasty may be a benefit of the Plan if there is gross disproportion present, or in association with approved unilateral augmentation mammoplasty or post mastectomy reconstruction of the contralateral breast.**
- OHIP authorization is required.

(d) Male Mastectomy

- This procedure is a benefit of the Plan.
- The appropriate code for the procedure is R115 or R116.
- Authorization is not required.

(e) Accessory breasts or accessory nipples

- Excision of such accessory tissue is a benefit of the Plan.
- The appropriate code should be used from the Schedule listings under Skin and Subcutaneous tissue.
- Authorization is not required.

PREAMBLE

5. Excision of excess fatty tissue

- This is a benefit of the Plan only if there is significant associated symptomatology such as intertrigo, pain or excoriations.
- When performed for alteration of appearance, the removal of redundant skin and fat, from the abdomen, extremities, etc. is not a benefit of the Plan.
- OHIP authorization is required.

Sex-Reassignment Surgery

- (1) Sex-reassignment surgical procedures are a benefit of OHIP only if they are performed on patients who have completed the Gender Identity Clinic program operated by the Clarke Institute of Psychiatry in Toronto. Moreover, claims are accepted for payment only for those patients for whom the Clinic has recommended that surgery take place. This surgery need not take place in Toronto or even in Ontario. Surgery recommended by the Clinic which takes place outside the Province of Ontario may be approved for payment at rates in accordance with the current OHIP Schedule of Benefits.
- (2) Within the foregoing guidelines, reconstruction of genitalia and mastectomy are benefits of the Plan. However, since the hormonal treatments associated with sex-reassignment themselves give rise to breast enlargement, augmentation mammoplasty or breast reconstruction in a male to female conversion normally would not be a benefit of OHIP, in keeping with the previously outlined policy regarding breast surgery in females.
- (3) OHIP authorization is required.

Complications and/or Revisions

- (1) The treatment of acute medical or surgical complications resulting from surgery for alteration of appearance and/or function is a benefit of the Plan whether or not the original surgery was covered by OHIP. This includes complications resulting from trans-sexual surgery (such as breakdown of the artificial vaginal wall). No authorization is required.
- (2) Revision of surgery for alteration of appearance, because of undesirable results, is a benefit of the Plan if the original surgery was a benefit *and* if the revision either is part of a pre-planned staged process or occurs within a reasonable period of convalescence. Correction of the effects on appearance which are due to complications, is a benefit of the Plan if it is carried out within a reasonable period of convalescence. OHIP authorization is required only if the original surgical procedure, if it had been carried out at the time of the proposed revision, would have required such authorization. For example, authorization would not be required for revision in a 16-year-old of a repaired congenital ear deformity. However, if the child is 18 years or older at the time of the revision, authorization would be required.

CONSULTATIONS AND VISITS

Code

\$

FAMILY PRACTICE AND PRACTICE IN GENERAL (00)

General Listings:

(Use these listings when performed at locations other than those designated in the following sections)

A005	Consultation	35.40
A006	Repeat consultation	26.20
A003	General assessment	31.90
A004	General re-assessment	18.40
A903	Pre-dental general assessment	27.60
A904	Pre-dental general re-assessment	18.40
A007	Intermediate assessment	14.50
A001	Minor assessment	11.00
A002	Well baby care (up to 2nd birthday)	12.75
K017	Annual Health Examination — child (after 2nd birthday)	19.10
K009	— adolescent, adult	27.60
A009	Oculo-visual assessment (including refraction and tonometry)	24.80
N.C.	Telephone advice including renewal of prescription	N.A.B.
N.C.	Dispensing service fee	N.A.B.

Non-emergency Hospital In-patient Services

Note: For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d))

C005	Consultation	35.40
C006	Repeat consultation	26.20
C003	General assessment	31.90
C004	General re-assessment	18.40
C903	Pre-dental general assessment	27.60
C904	Pre-dental general re-assessment	18.40
Subsequent visits (minor assessments):		
C002	up to five weeks	per visit 9.60
C007	from sixth to thirteenth week inclusive (not to exceed \$28.80 per week)	per visit 9.60
C009	after thirteenth week (not to exceed \$57.60 per month)	per visit 9.60
C008	Concurrent care (minor assessments) (See Preamble)	per visit 9.60
C010	Supportive care (minor assessments):	
See definition in Preamble. The physician may claim for this care on a per visit basis (not to exceed four such visits during the first week and not to exceed two such visits each week thereafter)		
		per visit 8.10

Note: If medical complications develop or are present in the post-operative period, hospital medical care may be claimed rather than supportive post-operative care. Such claims should be substantiated by the physician.

CONSULTATIONS AND VISITS

Code	FAMILY PRACTICE AND PRACTICE IN GENERAL – Cont'd	\$
H007	Attendance at maternal delivery for care of a high risk baby(s) — (if only service rendered at time of delivery)	39.00
Note:	Consultation should not be claimed with attendance at maternal delivery. — other fees may apply.	
H001	Newborn care in hospital and/or home	34.00
H002	Low birth weight baby care (uncomplicated) initial visit (per baby)	21.25
H003	— thereafter per visit	11.00
Emergency Department — Physician on Duty:		
Note:	A physician on duty in Emergency, called to see a hospital bed patient because of acute complications may not claim special visit surcharges. See Preamble, Part B, paragraph 16(d)	
H103	Multiple systems assessment — includes interpretation of x-ray, E.C.G. and other laboratory data as required	17.00
H101	Minor assessment — no additional benefit for interpretation of x-ray, E.C.G. and other laboratory data	8.85
When above visits and/or other services are rendered by the physician on duty in premium hours, apply one of the following premiums per patient visit to H101 or H103. Where no assessment fee (H101, H103) is chargeable, the premium to be added to the procedure(s) per patient visit is one of the following:		
H110	— 12 midnight to 8:00 a.m. — 50% of (H103)	8.50
H106	— Saturdays, Sundays or Holidays — 20% of (H103)	3.40
Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in Emergency or O.P.D.: (Use General Listings)		
Long Term Institutional Care:		
Note:	For emergency calls and other visits to institutional patients for which "special visit" premiums would apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in Institution refer to paragraph 18.)	
1. Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, or other Institutions in which patients are covered by extended care legislation:		
W105	Consultation	35.40
W106	Repeat consultation	26.20
Admission assessment (see Preamble)		
W102	Type 1	31.90
W104	2	11.00
W109	Annual physical examination	27.60
W004	General re-assessment of patient in nursing home or covered by extended care legislation	11.00
Note:	May only be claimed 6 months after Annual Health Examination (as per The Nursing Homes Act, 1972)	

CONSULTATIONS AND VISITS

Code	FAMILY PRACTICE AND PRACTICE IN GENERAL – Cont'd	\$
W903	Pre-dental general assessment	27.60
W904	Pre-dental general re-assessment	18.40

Subsequent visits (minor assessments)

	— chronic care or convalescent hospital (maximum of 10 per patient, per month)	
W002	— first two visits per month (chargeable by most responsible physician)	per visit 9.60
W001	— subsequent visits per month	per visit 7.10
	— nursing home or other institution covered by extended care legislation (maximum of 5 per patient, per month)	
W003	— first visit per month (chargeable by most responsible physician)	per visit 9.60
W008	— subsequent visits per month	per visit 7.10

2. Homes for the Aged, and other Institutions in which patients are Not Covered by Extended Care Legislation: (Use General Listings)

Note: General Listings under these circumstances also apply to patients seen in bed rather than in an office supplied by the institution.

Psychotherapy: (includes narcoanalysis, psychoanalysis or treatment of sexual dysfunction) (See Preamble, part B, paragraph 10)

K007	Individual — per ½ hour or major part thereof (see Preamble)	29.80
	Group — (four to eight people) per ½ hour or major part thereof	
K012	— per member (up to six hours per day)	5.50
N.C.	— per member (more than 6 hours per day)	N.A.B.
K004	Family — (two or more family members in attendance at the same time) per ½ hour or major part thereof	33.65

Hypnotherapy:

K006	Individual — per ½ hour or major part thereof	28.30
Note:	May not be claimed with diagnosis of acne, psoriasis, smoking, obesity or in conjunction with delivery.	

K011	Group, for induction and training for hypnosis (up to eight people) per ½ hour or major part thereof per member — (not applicable to prenatal patients)	5.30
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K013	Counselling —intended as an educational experience — not intended for ongoing therapy or as a substitute for a patient assessment (see Preamble, part B, paragraph 11) — one or more people per ½ hour or major part thereof	28.30
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CONSULTATIONS AND VISITS

Code	FAMILY PRACTICE AND PRACTICE IN GENERAL – Cont'd	\$
	Genetic Counselling: (See Preamble, Part B, paragraph 12)	
K019	Individual or family, per ½ hour (maximum 2 hours)	33.65
K020	Interview with relatives, per ½ hour (maximum 2 hours)	33.65
Note:	1.) Psychotherapy or hypnotherapy or counselling is not to be claimed in conjunction with other consultations or assessments rendered by the same physician during the same patient visit unless there are clearly defined unrelated diagnoses for the two services. 2.) The College of Physicians and Surgeons has stated that the minimum time period for psychotherapy (to be claimed as such) is 20 minutes. (See Preamble, part B, paragraph 10.) 3.) Advice given during a visit for patient assessment and relative to that assessment (see definitions) is included in the assessment benefit and does not qualify for "counselling".	
	Certification of Mental Illness	
K623	Application for psychiatric assessment, (as mandated by the Mental Health Act) — including necessary history, examination and completion of form	46.05
K624	Certification and re-certification of involuntary admission (as required by the Mental Health Act at not more than 120 hours and 2 weeks) — to include history, examination and completion of form per ½ hour or major part thereof	33.65
K629	All other re-certification(s) of involuntary admission	17.70
Note:	Consultation or assessment normally may not be claimed in addition.	
	Interviews:	
K002	Interviews with relatives on behalf of a patient, per ½ hour or major part thereof	28.30
K003	Interviews with C.A.S. or legal guardian on behalf of a patient, per ½ hour or major part thereof	28.30
Note:	K002, K003 — Should be claimed on the patient's claim card with diagnosis. These listings apply to situations where medically necessary information cannot be obtained from or given to the patient (e.g. because of illness, incompetence, etc). Diagnostic interview and/or counselling with child and/or parent: for psychological problem or learning disabilities per ½ hour	29.80
K008	Claims for K008 should be submitted on child's card.	
N.C.	for testing per ½ hour	N.A.B.
N.C.	Interviews with other paramedical organization or others on behalf of a patient, per ½ hour or major part thereof	N.A.B.
N.C.	Case conference — with medical and/or paramedical personnel on behalf of a patient, per ½ hour or major part thereof	N.A.B.

CONSULTATIONS AND VISITS

Code	FAMILY PRACTICE AND PRACTICE IN GENERAL – Cont'd	\$
	Certification and Reports:	
	With or Without Examination	
N.C.	Certification of health (ordinary), disability, or immunization status	N.A.B.
N.C.	Free from infection (barbers, waiters, etc.)	N.A.B.
N.C.	Insurance report based on previous examination	N.A.B.
N.C.	Insurance report on illness or death	N.A.B.
N.C.	Medico-legal reports	N.A.B.

Sexual Assault Investigation

Examination and documentation for investigation and/or confirmation of alleged sexual assault

K018	— female	170.00*
K021	— male	140.00*

* A portion of the listed benefits for K018 and K021 is recovered by OHIP from the Ministries of the Attorney General and the Solicitor General.

Premiums for Special Visits; I.C.U., C.C.U.; Detention:

(See Preamble, Part B, paragraphs 20, 21.)

ALLERGY (39)

Since the Royal College of Physicians and Surgeons of Canada has not set a standard for "Allergy Specialist", benefits for consultations and visits shall be applicable to a special allergist as they refer to him in his own General or Specialty Section except for the following:

K399	Clinical interpretation by immunologists where a report of a survey is submitted in writing to the patient's physician (not to apply when the immunologist claims for a consultation)	17.70
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ANAESTHESIA (01)

General Listings:

(Use these listings when performed at locations other than those designated in the following sections)

A015	Consultation	49.60
A016	Repeat consultation	31.90
A013	Specific assessment	28.30
A014	Specific re-assessment	17.70
A011	Minor assessment	11.00

Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:

(Use General Listings)

CONSULTATIONS AND VISITS

Code	ANAESTHESIA – Cont'd	\$
	Non-emergency Hospital In-patient Services:	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)	
C015	Consultation (See Preamble-paragraph 33(a))	49.60
C016	Repeat consultation (See Preamble-paragraph 33 (a))	31.90
C013	Specific assessment	28.30
C014	Specific re-assessment	17.70
	Subsequent visits; (minor assessments)	
C012	up to five weeks	per visit 11.00
C017	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week)	per visit 11.00
C019	after thirteenth week (not to exceed \$66.00 per month)	per visit 11.00
C018	Concurrent care (minor assessments)	per visit 11.00

Premiums for special visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs 20, 21.)

CARDIOLOGY (60)

For services not listed, refer to Internal Medicine Section

General Listings:

(Use these listings when performed at locations other than those designated in the following sections)

A605	Consultation	70.90
A645	Limited consultation	46.05
A606	Repeat consultation	46.05
A603	General assessment	39.00
A604	General re-assessment	28.30
A608	Specific re-assessment	17.00
A601	Minor assessment	11.00

Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.

(Use General Listings)

Non-emergency Hospital In-patient Services:

Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use general listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)	
C605	Consultation	70.90
C645	Limited consultation	46.05
C606	Repeat consultation	46.05
C603	General assessment	39.00

CONSULTATIONS AND VISITS

Code	CARDIOLOGY – Cont'd	\$
C604	General re-assessment	28.30
	Subsequent visits (minor assessments):	
C602	up to five weeks per visit	11.00
C607	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week) per visit	11.00
C609	after thirteenth week (not to exceed \$66.00 per month) per visit	11.00
C608	Concurrent care (minor assessments) per visit	11.00

Premiums for special visits; I.C.U.; C.C.U.; Detention:
(See Preamble, Part B, paragraphs 20, 21)

CARDIOVASCULAR AND THORACIC SURGERY (09)

General Listings:

(Use these listings when performed at locations other than those designated in the following sections)

A095	Consultation	35.40
A096	Repeat consultation	28.30
A093	Specific assessment	24.80
A094	Specific re-assessment	16.65
A091	Minor assessment	11.00

Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:

(Use General Listings)

Non-emergency Hospital In-patient Services:

Note: For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)

C095	Consultation	35.40
C096	Repeat consultation	28.30
C093	Specific assessment	24.80
C094	Specific re-assessment	16.65
	Subsequent visits (minor assessments):	
C092	up to five weeks per visit	11.00
C097	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week) per visit	11.00
C099	after thirteenth week (not to exceed \$66.00 per month) per visit	11.00
C098	Concurrent care (minor assessments) per visit	11.00

Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes:

W095	Consultation	35.40
W096	Repeat consultation	28.30

CONSULTATIONS AND VISITS

Code **CARDIOVASCULAR AND THORACIC SURGERY – Cont'd**
Premiums for special visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs 20, 21)

5

CLINICAL BIOCHEMISTRY (30)

General Listings:

(use these listings when performed at locations other than those designated in the following sections)

A305	Consultation	46.05
A306	Repeat or limited consultation	31.90
Non-emergency Hospital In-patient Services:		
C305	Consultation	46.05
C306	Repeat or limited consultation	31.90
C308	Concurrent care (minor assessments) per visit	11.00
Outpatient Department:		
H305	Consultation	46.05
H307	Repeat or limited consultation	31.90

Premiums for special visits; I.C.U., C.C.U.; Detention:
(see Preamble, Part B, paragraphs 20, 21)

CLINICAL IMMUNOLOGY (62)

For services not listed, refer to Internal Medicine Section.

General Listings:

(use these listings when performed at locations other than those designated in the following sections)

A625	Consultation	70.90
A525	Limited consultation	46.05
A626	Repeat consultation	46.05
A623	General assessment	39.00
A624	General re-assessment	28.30
A628	Specific re-assessment	17.00
A621	Minor assessment	11.00

**Emergency or O.P.D. — Physician in Hospital But Not on Duty in the
Emergency Department When Seeing Patient(s) in the Emergency or
O.P.D.:**

(use General Listings)

Non-emergency Hospital In-patient Services:

Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)	
C625	Consultation	70.90

CONSULTATIONS AND VISITS

Code	CLINICAL IMMUNOLOGY - Cont'd	\$
C525	Limited consultation	46.05
C626	Repeat consultation	46.05
C623	General assessment	39.00
C624	General re-assessment	28.30
	Subsequent visits (minor assessments):	
C622	up to five weeks	per visit 11.00
C627	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week)	per visit 11.00
C629	after thirteenth week (not to exceed \$66.00 per month)	per visit 11.00
C628	Concurrent care (minor assessments)	per visit 11.00

Premiums for special visits; I.C.U., C.C.U.; Detention:
(see Preamble, Part B, paragraphs 20, 21.)

DERMATOLOGY (02)

General Listings:

(use these listings when performed at locations other than those designated in the following sections.)

A025	Consultation	35.40
A026	Repeat consultation	28.30
A023	Specific assessment	24.80
A024	Specific re-assessment	16.65
A021	Minor assessment	11.00

Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:

(Use General Listings)

Non-emergency Hospital In-patient Services:

Note: For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)

C025	Consultation	35.40
C026	Repeat consultation	28.30
C023	Specific assessment	24.80
C024	Specific re-assessment	16.65
	Subsequent visits (minor assessments):	
C022	up to five weeks	per visit 11.00
C027	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week)	per visit 11.00
C029	after thirteenth week (not to exceed \$66.00 per month)	per visit 11.00
C028	Concurrent care (minor assessments)	per visit 11.00

CONSULTATIONS AND VISITS

Code	DERMATOLOGY - Cont'd	\$
	Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes.	
W025	Consultation	35.40
W026	Repeat consultation	28.30

Premiums for special visits; I.C.U., C.C.U.; Detention:
(see Preamble, Part B, paragraphs 20, 21.)

GASTROENTEROLOGY (41)

For services not listed, refer to Internal Medicine Section.

General Listings:

(Use these listings when performed at locations other than those designated in the following sections.)

A415	Consultation	70.90
A545	Limited consultation	46.05
A416	Repeat consultation	46.05
A413	General assessment	39.00
A414	General re-assessment	28.30
A418	Specific re-assessment	17.00
A411	Minor assessment	11.00

Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:

(Use General Listings)

Non-emergency Hospital In-patient Services:

Note: For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)

C415	Consultation	70.90
C545	Limited consultation	46.05
C416	Repeat consultation	46.05
C413	General assessment	39.00
C414	General re-assessment	28.30
	Subsequent visits (minor assessments):	
C412	up to five weeks	per visit 11.00
C417	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week)	per visit 11.00
C419	after thirteenth week (not to exceed \$66.00 per month)	per visit 11.00
C418	Concurrent care (minor assessments)	per visit 11.00

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs 20, 21.)

CONSULTATIONS AND VISITS

Code	GENERAL SURGERY (03)	\$
	General Listings: (Use these listings when performed at locations other than those designated in the following sections.)	
A035	Consultation	35.40
A036	Repeat consultation	28.30
A033	Specific assessment	24.80
A034	Specific re-assessment	16.65
A031	Minor assessment	11.00

**Emergency or O.P.D. — Physician in Hospital But Not on Duty in the
Emergency Department When Seeing Patient(s) in the Emergency or
O.P.D.:**

(Use General Listings)

Non-emergency Hospital In-patient Services:

Note:	For emergency calls and office visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)	
C035	Consultation	35.40
C036	Repeat consultation	28.30
C033	Specific assessment	24.80
C034	Specific re-assessment	16.65
	Subsequent visits (minor assessments):	
C032	up to five weeks	per visit 11.00
C037	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week)	per visit 11.00
C039	after thirteenth week (not to exceed \$66.00 per month)	per visit 11.00
C038	Concurrent care (minor assessments)	per visit 11.00

**Long Term Institutional Care — Chronic and Convalescent Hospital, Homes
for the Aged — Patients Covered by Extended Care Legislation and
Nursing Homes:**

W035	Consultation	35.40
W036	Repeat consultation	28.30

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(see Preamble, Part B, paragraphs 20, 21.)

HAEMATOLOGY (61)

For Services not listed, refer to Internal Medicine Section.

General Listings:

(Use these listings when performed at locations other than those designated in the following sections.)

A615	Consultation	70.90
A655	Limited consultation	46.05

CONSULTATIONS AND VISITS

Code	HAEMATOLOGY - Cont'd	\$
A616	Repeat consultation	46.05
A613	General assessment	39.00
A614	General re-assessment	28.30
A618	Specific re-assessment	17.00
A611	Minor assessment	11.00

Emergency or O.P.D.: — Physician in Hospital But not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:

(Use General Listings)

Non-emergency Hospital In-patient Services:

Note: For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)

C615	Consultation	70.90
C655	Limited consultation	46.05
C616	Repeat consultation	46.05
C613	General assessment	39.00
C614	General re-assessment	28.30
Subsequent visits (minor assessments):		
C612	up to five weeks	per visit 11.00
C617	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week)	per visit 11.00
C619	after thirteenth week (not to exceed \$66.00 per month)	per visit 11.00
C618	Concurrent care (minor assessments)	11.00

Premiums for Special Visits; I.C.U., C.C.U.; Detention:

(See Preamble, Part B, paragraphs 20, 21.)

INTERNAL MEDICINE (13)

General Listings:

(Use these listings when performed at locations other than those designated in the following sections.)

A135	Consultation	70.90
A435	Limited consultation	46.05
A136	Repeat consultation	46.05
A133	General assessment	39.00
A134	General re-assessment	28.30
A138	Specific re-assessment	17.00
A131	Minor assessment	11.00

Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:

(Use General Listings)

CONSULTATIONS AND VISITS

Code	INTERNAL MEDICINE – Cont'd	\$
	Non-emergency Hospital In-Patient Services:	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)	
C135	Consultation	70.90
C435	Limited consultation	46.05
C136	Repeat consultation	46.05
C133	General assessment	39.00
C134	General re-assessment	28.30
	Subsequent visits (minor assessments):	
C132	up to five weeks	per visit 11.00
C137	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week)	per visit 11.00
C139	after thirteenth week (not to exceed \$66.00 per month)	per visit 11.00
C138	Concurrent care (minor assessments)	per visit 11.00
	Long Term Institutional Care:	
Note:	For emergency calls and other visits to institutional patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in Institution, refer to paragraph 18.)	
	1. Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, or other Institutions in which patients are covered by extended care legislation:	
W235	Consultation	70.90
W435	Limited consultation	46.05
W236	Repeat consultation	46.05
	Admission assessment (see Preamble)	
W232	Type 1	31.90
W234	Type 2	11.00
W239	Annual physical examination	27.60
W134	General re-assessment of patient in nursing home or covered by extended care legislation	11.00
Note:	May only be claimed 6 months after Annual Health Examination (as per The Nursing Home Act, 1972)	
	Subsequent visits (minor assessments)	
	— chronic care or convalescent hospital (maximum of 10 per patient, per month)	
W132	— first two visits per month (chargeable by most responsible physician)	per visit 11.00
W131	— subsequent visits per month	per visit 8.50

CONSULTATIONS AND VISITS

Code	INTERNAL MEDICINE - Cont'd	\$
	— nursing home or other institution covered by extended care legislation (maximum of 5 per patient, per month)	
W133	— first visit per month (chargeable by most responsible physician)	per visit 11.00
W138	— subsequent visits per month	per visit 8.50

2. Homes for the Aged and other Institutions in which patients are Not Covered by Extended Care Legislation:

(Use General Listings)

Note: General Listings under these circumstances also apply to patients seen in bed rather than in an office supplied by the institution.

Premiums for Special Visits; I.C.U., C.C.U.; Detention:

(See Preamble, Part B, paragraphs 20, 21.)

MICROBIOLOGY (29)

General Listings:

(Use these listings for services other than non-emergency hospital services.)

A295	Consultation	46.05
A297	Limited consultation	31.90
A296	Repeat consultation	31.90

Non-emergency Hospital In-patient Services:

C295	Consultation	46.05
C297	Limited consultation	31.90
C296	Repeat consultation	31.90
C298	Concurrent care	per visit 11.00

Outpatient Department:

H295	Consultation	46.05
H297	Limited Consultation	31.90
H293	Repeat consultation	31.90

Premiums for Special Visits; I.C.U., C.C.U.; Detention:

(See Preamble, Part B, paragraphs 20, 21.)

NEUROLOGY (18)

General Listings:

(Use these listings when performed at locations other than those designated in the following sections.)

A185	Consultation	70.90
A385	Limited consultation	46.05
A186	Repeat consultation	46.05
A183	General assessment	39.00

CONSULTATIONS AND VISITS

Code	NEUROLOGY - Cont'd	\$
A184	General re-assessment	28.30
A188	Specific re-assessment	17.00
A181	Minor assessment	11.00

Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:

(Use General Listings)

Non-emergency Hospital In-patient Services:

Note: For emergency calls and other visits to hospital in-patients for which
"special visit" premiums apply, use General Listings and refer to
Preamble, Part B, paragraph 20. (If physician already in hospital, refer to
paragraph 16(d).)

C185	Consultation	70.90
C385	Limited consultation	46.05
C186	Repeat consultation	46.05
C183	General assessment	39.00
C184	General re-assessment	28.30
	Subsequent visits (minor assessments):	
C182	up to five weeks	per visit 11.00
C187	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week)	per visit 11.00
C189	after thirteenth week (not to exceed \$66.00 per month)	per visit 11.00
C188	Concurrent care (minor assessments)	per visit 11.00

Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes:

W185	Consultation	70.90
W385	Limited consultation	46.05
W186	Repeat consultation	46.05

Premiums for Special Visits; I.C.U., C.C.U.; Detention:

(See Preamble, Part B, paragraphs 20, 21.)

NEUROSURGERY (04)

General Listings:

(Use these listings when performed at locations other than those designated
in the following sections.)

A045	Consultation	53.10
A046	Repeat consultation	30.10
A043	Specific assessment	30.10
A044	Specific re-assessment	16.65
A041	Minor assessment	11.00

CONSULTATIONS AND VISITS

Code	NEUROSURGERY — Cont'd	\$
	Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:	
	(Use General Listings)	
	Non-emergency Hospital In-patient Services:	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)	
C045	Consultation	53.10
C046	Repeat consultation	30.10
C043	Specific assessment	30.10
C044	Specific re-assessment	16.65
	Subsequent visits (minor assessments):	
C042	up to five weeks	per visit 11.00
C047	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week)	per visit 11.00
C049	after thirteenth week (not to exceed \$66.00 per month)	per visit 11.00
C048	Concurrent care (minor assessments)	per visit 11.00
	Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes:	
W045	Consultation	53.10
W046	Repeat consultation	30.10
	Premiums for Special Visits; I.C.U., C.C.U.; Detention: (see Preamble, Part B, paragraphs 20, 21.)	
	NUCLEAR MEDICINE (63)	
G635	Consultation	39.00
G634	Repeat consultation	28.30
G935	Diagnostic consultation — see definition in Preamble	17.70
G632	Specific re-assessment	17.00
G631	Minor assessment	11.00
	Premiums for Special Visits; I.C.U., C.C.U.; Detention: (See Preamble, Part B, paragraphs 20, 21.)	

CONSULTATIONS AND VISITS

Code	OBSTETRICS AND GYNAECOLOGY (20)	\$
General Listings:		
(Use these listings when performed at locations other than those designated in the following sections.)		
A205	Consultation*	35.40
A206	Repeat consultation*	28.30
A203	Specific assessment*	24.80
A204	Specific re-assessment*	16.65
A201	Minor assessment	11.00

**Emergency or O.P.D. — Physician in Hospital But Not on Duty in the
Emergency Department When Seeing Patient(s) in the Emergency or
O.P.D.:**

(Use General Listings)

Non-emergency Hospital In-patient Services:

Note: For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)

C205	Consultation*	35.40
C206	Repeat consultation*	28.30
C203	Specific assessment*	24.80
C204	Specific re-assessment*	16.65
Subsequent visits (minor assessments):		
C202	up to five weeks per visit	11.00
C207	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week) per visit	11.00
C209	after thirteenth week (not to exceed \$66.00 per month) per visit	11.00
C208	Concurrent care (minor assessments) per visit	11.00

**Long Term Institutional Care — Chronic and Convalescent Hospitals,
Homes for the Aged — Patients Covered by Extended Care Legislation and
Nursing Homes:**

W305	Consultation*	35.40
W306	Repeat consultation*	28.30

Premiums for Special Visits; I.C.U., C.C.U.; Detention:

(See Preamble, Part B, paragraphs 20, 21.)

*May include chemical cautery, biopsy of cervix, Papanicolaou smear, examination of trichomonas suspension.

CONSULTATIONS AND VISITS

Code	OPHTHALMOLOGY (23)	\$
	General Listings: (Use these listings when performed at locations other than those designated in the following sections.)	
A235	Consultation	35.40
A236	Repeat consultation	28.30
A233	Specific assessment	24.80
A234	Specific re-assessment	16.65
A231	Minor assessment	11.00

**Emergency or O.P.D. — Physician in Hospital But Not on Duty in the
Emergency Department When Seeing Patient(s) in the Emergency or
O.P.D.:**
(Use General Listings)

Non-emergency Hospital In-patient Services:

Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)	
C235	Consultation	35.40
C236	Repeat consultation	28.30
C233	Specific assessment	24.80
C234	Specific re-assessment	16.65
	Subsequent visits (minor assessments):	
C232	up to five weeks	per visit 11.00
C237	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week)	per visit 11.00
C239	after thirteenth week (not to exceed \$66.00 per month)	per visit 11.00
C238	Concurrent care (minor assessments)	per visit 11.00

**Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and
Nursing Homes:**

W535	Consultation	35.40
W536	Repeat consultation	28.30

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(see Preamble, Part B, paragraphs 20, 21.)

ORTHOPAEDIC SURGERY (06)

General Listings:

(Use these listings when performed at locations other than those designated in the following sections.)

A065	Consultation	33.30
A066	Repeat consultation	26.20
A063	Specific assessment	22.00

CONSULTATIONS AND VISITS

Code	ORTHOPAEDIC SURGERY - Cont'd	\$
A064	Specific re-assessment	15.60
A061	Minor assessment	11.00

**Emergency or O.P.D. — Physician in Hospital But Not on Duty in the
Emergency Department When Seeing Patient(s) in the Emergency or
O.P.D.:**

(Use General Listings)

Non-emergency Hospital In-patients Services:

Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)	
C065	Consultation	33.30
C066	Repeat consultation	26.20
C063	Specific assessment	22.00
C064	Specific re-assessment	15.60
	Subsequent visits (minor assessments):	
C062	up to five weeks	per visit 9.60
C067	from sixth to thirteenth week inclusive (not to exceed \$28.80 per week)	per visit 9.60
C069	after thirteenth week (not to exceed \$57.60 per month)	per visit 9.60
C068	Concurrent care (minor assessments)	per visit 9.60

**Long Term Institutional Care — Chronic and Convalescent Hospital, Homes
for the Aged — Patients Covered by Extended Care Legislation and
Nursing Homes:**

W065	Consultation	33.30
W066	Repeat consultation	26.20

Subsequent visits (minor assessments)

— chronic care or convalescent hospital (maximum of 10 per patient, per
month)

W062	— first two visits per month (chargeable by most responsible physician)	per visit 9.60
W061	— subsequent visits per month	per visit 8.50
	— nursing home or other institution covered by extended care legislation (maximum of 5 per patient, per month)	
W063	— first visit per month (chargeable by most responsible physician)	per visit 9.60
W068	— subsequent visits per month	per visit 8.50

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs 20, 21.)

CONSULTATIONS AND VISITS

Code	OTOLARYNGOLOGY (24)	\$
	General Listings: (Use these listings when performed at locations other than those designated in the following sections.)	
A245	Consultation	35.40
A246	Repeat consultation	28.30
A243	Specific assessment	24.80
A244	Specific re-assessment	16.65
A241	Minor assessment	11.00
	Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: (Use General Listings)	
	Non-emergency Hospital In-patient Services:	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)	
C245	Consultation	35.40
C246	Repeat consultation	28.30
C243	Specific assessment	24.80
C244	Specific re-assessment	16.65
	Subsequent visits (minor assessments):	
C242	up to five weeks	per visit 11.00
C247	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week)	per visit 11.00
C249	after thirteenth week (not to exceed \$66.00 per month)	per visit 11.00
C248	Concurrent care (minor assessments)	per visit 11.00
	Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes:	
W345	Consultation	35.40
W346	Repeat consultation	28.30
	Premiums for Special Visits; I.C.U., C.C.U.; Detention: (See Preamble, Part B, paragraphs 20, 21.)	
	PAEDIATRICS (26)	
	General Listings: (Use these listings when performed at locations other than those designated in the following sections.)	
A265	Consultation	70.90
A665	Prenatal consultation (see Preamble, Part B, paragraph 1(1))	42.50
A565	Limited consultation	46.05

CONSULTATIONS AND VISITS

Code	PAEDIATRICS - Cont'd	\$
A266	Repeat consultation	46.05
A263	General assessment	32.95
A264	General re-assessment	21.25
A268	Specific re-assessment	15.60
A261	Minor assessment	11.00
A262	Well baby care (up to 2nd birthday)	12.75
K267	Annual health examination — child (after 2nd birthday)	19.10
K269	— adolescent	27.60
	Diagnostic interview and/or counselling with child and/or parent — see Practice in General Listing (K008)	

Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:

(Use General Listings)

Non-emergency Hospital In-patient Services:

Note: For emergency calls and other visits to hospital in-patients for which
"special visit" premiums apply, use General Listings and refer to
Preamble, Part B, paragraph 20 (If physician already in hospital, refer to
paragraph 16(d).)

C265	Consultation	70.90
C665	Prenatal consultation (See Preamble, part B, paragraph 3(1))	42.50
C565	Limited consultation	46.05
C266	Repeat consultation	46.05
C263	General assessment	32.95
C264	General re-assessment	21.25
	Subsequent visits (minor assessments):	
C262	up to six weeks	per visit 11.00
C267	from seventh to thirteenth week inclusive (not to exceed \$33.00 per week)	per visit 11.00
C269	after thirteenth week (not to exceed \$66.00 per month)	per visit 11.00
C268	Concurrent care (minor assessments)	per visit 11.00
H267	Attendance at maternal delivery (one or more babies)	39.00
Note:	Consultation should not be claimed with attendance of maternal delivery other fees may apply. (See Obstetrical Preamble, paragraph 11.)	
H261	Newborn care in hospital and/or home	39.00
	Low birthweight baby care (uncomplicated)	
H262	— initial visit (per baby)	31.90
H263	— thereafter	per visit 11.00
U.V.C.	— Intensive care unit (without assisted ventilation) (See Preamble, Part B, paragraph 20(b))	visit fees
N.C.	Pre-adoption examination and evaluation	N.A.B.
	Chronic and Convalescent Hospital:	
W265	Consultation	70.90
W565	Limited consultation	46.05

CONSULTATIONS AND VISITS

Code	PAEDIATRICS – Cont'd	\$
W266	Repeat consultation	46.05
	Admission assessment (see Preamble)	
W562	Type 1	31.90
W564	Type 2	11.00

Subsequent visits (minor assessments)

— chronic care or convalescent hospital (maximum of 10 per patient, per month)

W262	— first two visits per month (chargeable by most responsible physician)	per visit 11.00
W261	— subsequent visits per month	per visit 7.80
W269	Annual physical examination	19.10

Note: In surgical cases requiring medical direction, standard in-hospital medical benefits may be claimed in addition to the surgical benefit.
This includes all operations on babies under one year of age, and all other children who require medical supervision.

Premiums for Special Visits; I.C.U., C.C.U.; Detention:

(See Preamble, Part B, paragraphs 20, 21.)

PATHOLOGY (28)

General Listings:

(Use these listings for services other than non-emergency in-patient services.)

A285	Consultation	46.05
A286	Repeat or limited consultation	31.90
A585	Diagnostic consultation — see definition in Preamble	17.70

Non-emergency Hospital In-patient Services:

C285	Consultation	46.05
C286	Repeat or limited consultation	31.90
C585	Diagnostic consultation	17.70
C288	Concurrent care	per visit 11.00

Premiums for Special Visits; I.C.U., C.C.U.; Detention:

(See Preamble, Part B, paragraphs 20, 21.)

PHYSICAL MEDICINE AND REHABILITATION (31)

General Listings:

(Use these listings when performed at locations other than those designated in the following sections.)

A315	Consultation	70.90
A515	Limited consultation	46.05

CONSULTATIONS AND VISITS

Code	PHYSICAL MEDICINE AND REHABILITATION - Cont'd	\$
A316	Repeat consultation	46.05
A313	General assessment	39.00
A310	General re-assessment	28.30
A314	Specific re-assessment	17.00
A311	Minor assessment	11.00

Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:

(Use General Listings)

Non-emergency Hospital In-patient Services:

Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)	
C315	Consultation	70.90
C515	Limited consultation	46.05
C316	Repeat consultation	46.05
C313	General assessment	39.00
C314	General re-assessment	28.30
	Subsequent visits (minor assessments):	
C312	up to five weeks	per visit 11.00
C317	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week)	per visit 11.00
C319	after thirteenth week (not to exceed \$66.00 per month)	per visit 11.00
C318	Concurrent care (minor assessments)	per visit 11.00

Long Term Institutional Care:

Note:	For emergency calls and other visits to institutional patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in Institution, refer to paragraph 18.)	
	1. Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes or other Institutions in which patients are covered by extended care legislation:	
W515	Consultation	70.90
W310	Limited consultation	46.05
W516	Repeat consultation	46.05
	Admission assessment (see Preamble)	
W512	Type 1	31.90
W514	Type 2	11.00
W419	Annual physical examination	27.60
W314	General re-assessment of patient in nursing home or covered by extended care legislation	11.00

CONSULTATIONS AND VISITS

Code	PHYSICAL MEDICINE AND REHABILITATION – Cont'd	\$
	May only be claimed 6 months after Annual Health Examination (as per The Nursing Homes Act, 1972).	
	Subsequent visits (minor assessments)	
	— chronic care or convalescent hospital (maximum of 10 per patient, per month)	
W312	— first two visits per month (chargeable by most responsible physician)	per visit 11.00
W311	— subsequent visits per month	per visit 8.50
	— nursing home or other institution covered by extended care legislation (maximum of 5 per patient, per month)	
W313	— first visit per month (chargeable by most responsible physician)	per visit 11.00
W318	— subsequent visits per month	per visit 8.50
	2. Homes for the Aged and other Institutions in which patients are Not Covered by Extended Care Legislation.	
	(Use General Listings)	
Note:	General Listings under these circumstances also apply to patients seen in bed rather than in an office supplied by the institution.	
	Premiums for Special Visits; I.C.U., C.C.U.; Detention:	
	(See Preamble, Part B, paragraphs 20, 21.)	
	Team Management in a Rehabilitation Unit: (Active in-patient rehabilitation management from the initiation of rehabilitation care as it applies to codes H312, H317 and H319 means, when this service is rendered by one physiatrist (even if part of the service is rendered in an active treatment hospital and part is rendered in a rehabilitation unit), the weekly and monthly limitations under these codes apply to the total rehabilitation care rendered. In other words, it is not possible to claim the maximum benefits allowed under codes C312, C317 and C319 and submit claims de novo under codes H312, H317 and H319 under the above circumstances.)	
H312	up to twelve weeks	per visit 11.00
H317	from thirteenth to twenty-sixth week (not to exceed \$33.00 per week)	per visit 11.00
H319	twenty-sixth week onwards (not to exceed \$66.00 per month)	per visit 11.00
	Rehabilitation Procedures:	
H313	Interviewing and counselling of patients and/or relatives per half hour or major part thereof (includes report)	28.30
N.C.	Rehabilitation case conference — with medical and/or paramedical personnel on behalf of a patient	N.A.B.
K313	Physiatric Management: applies to physiatrists regulating the day to day management of patients which may include (as required) prescription development, advice and supervision. It may be claimed on the days when rehabilitation services are provided to patients who have been seen previously by the physiatrist for consultation or assessment. The benefit is	

CONSULTATIONS AND VISITS

Code PHYSICAL MEDICINE AND REHABILITATION - Cont'd

5

not meant as an administrative allowance for supervising a department of rehabilitation nor is it to be claimed on the same day as claims are made for any other services which are provided by the physiatrist to the same patient(s)

2.20

PLASTIC SURGERY (08)

General Listings:

(Use these listings when performed at locations other than those designated in the following sections.)

A085	Consultation	35.40
A086	Repeat consultation	28.30
A083	Specific assessment	24.80
A084	Specific re-assessment	16.65
A081	Minor assessment	11.00

Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:

(Use General Listings)

Non-emergency Hospital In-patient Services:

Note: For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)

C085	Consultation	35.40
C086	Repeat consultation	28.30
C083	Specific assessment	24.80
C084	Specific re-assessment	16.65
Subsequent visits (minor assessments):		
C082	up to five weeks per visit	11.00
C087	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week) per visit	11.00
C089	after thirteenth week (not to exceed \$66.00 per month) per visit	11.00
C088	Concurrent care (minor assessments) per visit	11.00

Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes:

W085	Consultation	35.40
W086	Repeat consultation	28.30

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs 20, 21.)

CONSULTATIONS AND VISITS

Code	PSYCHIATRY (19)	5
General Listings:		
(Use these listings when performed at locations other than those designated in the following sections.)		
A195	Consultation	70.90
A395	Limited consultation	46.05
A196	Repeat consultation	46.05
A193	Specific assessment	39.00
A194	Specific re-assessment	28.30
A191	Minor assessment	11.00
Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:		
(Use General Listings)		
Non-emergency Hospital Services: (in-patient, day care, residential care).		
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)	
C195	Consultation	70.90
C395	Limited consultation	46.05
C196	Repeat consultation	46.05
C193	Specific assessment	39.00
C194	Specific re-assessment	28.30
Subsequent visits (minor assessment):		
C192	up to five weeks	per visit 11.00
C197	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week)	per visit 11.00
C199	after thirteenth week (not to exceed \$66.00 per month)	per visit 11.00
C198	Concurrent care (minor assessment)	per visit 11.00
Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes:		
W195	Consultation	70.90
W395	Limited consultation	46.05
W196	Repeat consultation	46.05
Other Services:		
Certification of Mental Illness		
K623	Application for psychiatric assessment, (as mandated by the Mental Health Act) — including necessary history, examination and completion of form	46.05
K624	Certification and re-certification of involuntary admission (as required by the Mental Health Act at not more than 120 hours and 2 weeks) — to include history, examination and completion of form, per ½ hour or major part thereof	33.65

CONSULTATIONS AND VISITS

Code	PSYCHIATRY - Cont'd	\$
K629	All other re-certification(s) of involuntary admission	17.70
Note:	Consultation or assessment normally may not be claimed in addition to certification or re-certification (same visit).	
N.C.	Specific assessment with report to referring agency	N.A.B.
A197	Consultation on behalf of disturbed child (including report):	
A198	consultative interview with parents	67.30
	consultative interview with child	67.30
	(Assessment conference with parents should be claimed on the basis of family therapy).	
N.C.	Therapeutic supervision with any para-medical organization (health education, correction and other community resources)	N.A.B.
Note:	Interviews with relatives, C.A.S. or Legal guardian on behalf of a patient, see K002, K003 on page 34.	
	Psychotherapy: (See Preamble, Part B, paragraph 10)	
K197	Individual (including Aversive Conditioning, Narcc analysis, Psychoanalysis) per ½ hour or major part thereof	33.65
	Group psychotherapy (4-8 people)	
K198	per member, per ½ hour or major part thereof (up to six hours per day) .	6.20
N.C.	per member, per hour (more than 6 hours)	N.A.B.
	Family therapy (two or more family members)	
K195	per ½ hour or major part thereof	39.00
Note:	Should be claimed on the patient's claim card with diagnosis.	
	Hypnotherapy:	
K192	Individual — per ½ hour or major part thereof	32.20
Note:	May not be claimed with diagnosis of acne, psoriasis, smoking, obesity or in conjunction with delivery.	
K194	Group — for induction and training for hypnosis (up to eight people) per ½ hour or major part thereof — per member — (not applicable to prenatal patients)	6.20
Note:	(1) For electroconvulsive therapy benefits, see Diagnostic and Therapeutic Procedures.	
	(2) Psychotherapy or hypnotherapy or counselling or E.C.T. is not to be claimed in conjunction with other consultations or assessments rendered by the same physician on the same day, unless there are clearly defined unrelated diagnoses for the two services.	
	(3) The College of Physicians and Surgeons has stated that the minimum time period for psychotherapy (to be claimed as such) is 20 minutes (see Preamble, Part B, paragraph 10).	

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs 20, 21.)

CONSULTATIONS AND VISITS

Code	RADIOLOGY — DIAGNOSTIC (33)	\$
	General Listing:	
A335	Consultation (See Preamble, Part B, paragraph 1(f))	18.10
	Non-Emergency Hospital Service:	
C335	Consultation (See Preamble, Part B, paragraph 1(f))	18.10
	Premiums for Special Visits; I.C.U., C.C.U.; Detention: (See Preamble, Part B, paragraphs 20, 21.)	

RADIATION ONCOLOGY — (THERAPEUTIC RADIOLOGY) (34)

	General Listings: (Use these listings when performed at locations other than those designated in the following sections.)	
A345	Consultation	39.00
A346	Repeat consultation	28.30
A343	Specific assessment	24.80
A344	Specific re-assessment	16.65
A341	Minor assessment	11.00
	Non-emergency Hospital In-patient Services:	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)	
C345	Consultation	39.00
C346	Repeat consultation	28.30
C343	Specific assessment	24.80
C344	Specific re-assessment	16.65
	Subsequent visits (minor assessments):	
C342	up to five weeks per visit	11.00
C347	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week) per visit	11.00
C349	after thirteenth week (not to exceed \$66.00 per month) per visit	11.00
C348	Concurrent care (minor assessments) per visit	11.00
	Premiums for Special Visits; I.C.U., C.C.U.; Detention: (see Preamble, Part B, paragraphs 20, 21.)	

RESPIRATORY DISEASE (47)

For services not listed, refer to Internal Medicine Section.

	General Listings: (Use these listings when performed at locations other than those designated in the following sections.)	
A475	Consultation	70.90
A575	Limited consultation	46.05

CONSULTATIONS AND VISITS

Code	RESPIRATORY DISEASE - Cont'd	\$
A476	Repeat consultation	46.05
A473	General assessment	39.00
A474	General re-assessment	28.30
A478	Specific re-assessment	17.00
A471	Minor assessment	11.00

**Emergency or O.P.D. — Physician in Hospital But Not on Duty in the
Emergency Department When Seeing Patient(s) in the Emergency or
O.P.D.:**

(Use General Listings)

Non-emergency Hospital In-patient Services:

Note: For emergency calls and other visits to hospital in-patients for which
"special visit" premiums apply, use General Listings and refer to
Preamble, Part B, paragraph 20. (If physician already in hospital, refer to
paragraph 16(d).)

C475	Consultation	70.90
C575	Limited consultation	46.05
C476	Repeat consultation	46.05
C473	General assessment	39.00
C474	General re-assessment	28.30
Subsequent visits (minor assessments):		
C472	up to five weeks	per visit 11.00
C477	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week)	per visit 11.00
C479	after thirteenth week (not to exceed \$66.00 per month)	per visit 11.00
C478	Concurrent care (minor assessments)	per visit 11.00

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs 20, 21.)

RHEUMATOLOGY (48)

For services not listed, refer to Internal Medicine Section.

General Listings:

(Use these listings when performed at locations other than those designated
in the following sections.)

A485	Consultation	70.90
A595	Limited consultation	46.05
A486	Repeat consultation	46.05
A483	General assessment	39.00
A484	General re-assessment	28.30
A488	Specific re-assessment	17.00
A481	Minor assessment	11.00

CONSULTATIONS AND VISITS

Code	RHEUMATOLOGY - Cont'd	\$
	Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:	
	(Use General Listings)	
	Non-emergency Hospital In-patient Services:	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)	
C485	Consultation	70.90
C595	Limited consultation	46.05
C486	Repeat consultation	46.05
C483	General assessment	39.00
C484	General re-assessment	28.30
	Subsequent visits (minor assessments):	
C482	up to five weeks	per visit 11.00
C487	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week)	per visit 11.00
C489	after thirteenth week (not to exceed \$66.00 per month)	per visit 11.00
C488	Concurrent care (minor assessments)	per visit 11.00
	Premiums for Special Visits; I.C.U., C.C.U.; Detention:	
	(See Preamble, Part B, paragraphs 20, 21.)	

UROLOGY (35)

General Listings:

(Use these listings when performed at locations other than those designated
in the following sections.)

A355	Consultation*	35.40
A356	Repeat consultation*	28.30
A353	Specific assessment*	24.80
A354	Specific re-assessment*	16.65
A351	Minor assessment	11.00

**Emergency or O.P.D. — Physician in Hospital But not on Duty in the
Emergency Department When Seeing Patient(s) in the Emergency or
O.P.D.:**

(Use General Listings)

*May include physical examination pertaining to the genito-urinary tract and when necessary such
procedures as urethral calibration and prostatic fluid examination, but not to include endoscopic ex-
amination.

CONSULTATIONS AND VISITS

Code	UROLOGY - Cont'd	\$
	Non-emergency Hospital In-patient Services:	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 20. (If physician already in hospital, refer to paragraph 16(d).)	
C355	Consultation*	35.40
C356	Repeat consultation*	28.30
C353	Specific assessment*	24.80
C354	Specific re-assessment*	16.65
	Subsequent visits (minor assessments):	
C352	up to five weeks	per visit 11.00
C357	from sixth to thirteenth week inclusive (not to exceed \$33.00 per week)	per visit 11.00
C359	after thirteenth week (not to exceed \$66.00 per month)	per visit 11.00
C358	Concurrent care (minor assessments)	per visit 11.00
	Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes:	
W355	Consultation*	35.40
W356	Repeat consultation*	28.30
	Premiums for Special Visits; I.C.U., C.C.U.; Detention: (See Preamble, Part B, paragraphs 20, 21.)	

*May include physical examination pertaining to the genito-urinary tract and when necessary such procedures as urethral calibration and prostatic fluid examination, but not to include endoscopic examination.



NUCLEAR MEDICINE — IN VIVO

Column T — is the technical benefit for the production of records, radiopharmaceutical agents, apparatus, premises, technical services, administration and secretarial services.

Column P₁ — is the professional benefit for supervision of the procedure, appropriate patient interview and/or examination, correlation of related data, interpretation of results, and provision of a written report. The physician must be present for supervision of the procedure to the extent that he or she may intervene personally, if required.

Column P₂ — is the professional benefit for interpretation of results and provision of a written report. If the physician is not present or if any visit is claimed in conjunction with that Nuclear Medicine procedure, the lesser professional benefit (P₂) should be claimed.

Notes: (1) The total benefit is arrived at by adding T plus P₁ (first code listed, e.g. Z006) or by adding T plus P₂ (second code listed, e.g. Z925).

When coding the total benefit use suffix A

When coding the technical portion only use suffix B

When coding the professional portion only use suffix C.

(2) If quantification or data manipulation is carried out in addition to visual inspection of imaging studies, add 30% to the appropriate professional benefit. Such activity must add significant diagnostic information not available by inspection alone and does not include simple image enhancement techniques such as smoothing, background subtraction, etc. Recording of images on videotape for replay and production of images on the video display of a computer do not in themselves justify the additional benefit.

For services for which this additional 30% is appropriate the correct code prefix is Y instead of Z. For example for Arteriography plus data manipulation, the appropriate codes are Y006/Y925 instead of Z006/Z925.

The benefits for cardiac wall motion studies and calculation of ventricular ejection fraction (Z010 and Z012) already include an allowance for data manipulation and no additional benefit may be claimed.

(3) If examination of Brain, Lung, Liver or Spleen is limited to one view, the benefit (T and P₁ and P₂) is to be reduced by 50% (use codes Z036/Z957, Z041/Z935, Z080/Z990 respectively).

(4) Repeat studies on the same day may be claimed only after exercise or drug intervention.

(5) The phrase "nuclear medicine specialist" should be interpreted as "nuclear medicine physician", since not all physicians practising nuclear medicine are certified as specialists in this discipline by the Royal College of Physicians and Surgeons.

(6) See also Preamble, part B, paragraph 1(i), 1(j) and 1(k).

NUCLEAR MEDICINE — IN VIVO

Code	Cardiovascular System	T \$	P ₁ \$	P ₂ \$
Z006/Z925	Arteriography — aorta and its branches, — uni or bilateral	63.80	19.80	9.90
Z008/Z927	Venography — uni or bilateral	63.80	22.30	11.20
Z013/Z928	— mediastinum and superior vena cava	38.30	22.30	11.20
Z007/Z926	Blood flow study in conjunction with static organ scan	25.50	11.20	5.60
Z004/Z922	Cardiac output	25.50	13.30	6.70
Z024/Z924	Cardioangiography	63.80	19.80	11.20
Z005/Z991	Myocardial perfusion scan — with Thallium ²⁰¹	132.50	23.20	12.00
Z025/Z994	Delayed Thallium ²⁰¹ myocardial perfusion scan	25.50	23.20	12.00
Z017/Z964	Myocardial perfusion scan — using other radionuclides	70.90	23.20	12.00
Z016/Z960	Myocardial scan — acute infarction, injury	63.80	19.80	9.90
	Myocardial wall motion studies			
Z010/Z923	— two or more projections	84.70	39.70	19.80
Z009/Z992	— repeat same day (maximum of 2 repeats)	25.50	19.80	—
Z012/Z988	Myocardial wall motion studies with ejection fraction	84.70	53.00	26.60
Z011/Z993	— repeat same day (maximum of 2 repeats)	25.50	26.60	—
Z018/Z965	Pericardial effusion scan	35.80	13.30	6.70
Z023/Z983	Detection and localization of venous thrombosis using radio iodinated fibrinogen up to ten days	84.70	20.60	10.30
	Endocrine System			
Z022/Z982	Ac ⁴¹ renal scan	132.50	33.20	6.70
Z027/Z930	Thyroid uptake per determination	18.40	10.60	6.70
Z078/Z974	Thyroid scan	44.60	19.60	6.70
Z019/Z975	Thyroid scan with uptake using same radio pharmaceutical	54.60	30.20	8.40
Z074/Z971	Parathyroid scan	63.80	22.30	6.70
	Gastrointestinal System			
Z040/Z934	Radio-labelled fat absorption study	22.70	6.70	6.70
Z043/Z936	Schilling test	36.10	6.70	6.70
Z044/Z937	Schilling test — repeat with intrinsic factor, or other	18.10	3.30	3.30
Z015/Z938	Schilling test with dual isotopes and intrinsic factor	36.10	8.60	8.60
Z057/Z939	C ¹⁴ labelled metabolite breath test	42.50	6.70	6.70
Z045/Z940	Protein loss or gastrointestinal bleeding	63.80	13.30	13.30
Z046/Z941	Ca ⁴⁷ absorption study	63.80	13.30	13.30
Z042/Z942	Gastrointestinal transit or reflux study	63.80	22.30	9.90

NUCLEAR MEDICINE — IN VIVO

Code	— Cont'd	T \$	P ₁ \$	P ₂ \$
Z088/Z977	Abdominal scan (ectopic gastric mucosa, G.I. bleed and shunt patency)	63.80	19.80	10.60
Z047/Z943	Pancreatic study (Selenium)	132.50	13.80	6.90
Z073/Z970	Pancreatic scan	132.50	22.30	11.20
Z058/Z951	Dynamic biliary excretion	63.80	22.30	11.20
	Liver and/or spleen scan			
Z080/Z990	— one view only	31.90	9.90	5.00
Z070/Z966	— more than one view	63.80	19.80	9.90
Z089/Z978	Salivary gland study	63.80	22.30	11.20
Genitourinary System				
Z063/Z953	Dynamic renal imaging study	63.80	22.30	11.20
Z060/Z952	Renogram (time-activity curves only)	35.40	13.30	6.70
Z076/Z973	Renal scan (static image only)	44.60	13.30	6.70
Z061/Z954	Renal plasma flow	35.40	13.80	6.90
Z062/Z955	Glomerular filtration rate	42.50	13.80	6.90
Z026/Z956	Cystogram for vesicoureteral reflux	63.80	22.30	11.20
Z075/Z972	Placenta	42.50	13.30	6.70
Z021/Z981	Testicles and scrotum	63.80	22.30	6.70
Hematopoietic System				
Z001/Z919	Plasma volume	18.40	4.60	4.60
Z002/Z920	Plasma volume with repeat studies	25.50	4.60	4.60
Z003/Z921	Red cell volume	26.90	4.00	4.00
Z050/Z945	Plasma iron clearance	45.35	6.70	6.70
Z051/Z946	Plasma iron turnover	45.35	6.70	6.70
Z052/Z947	Fe ⁵⁹ red cell utilization	45.35	13.30	6.70
Z053/Z948	Combination of Z050, Z051, Z052 at one time	99.20	13.30	13.30
Z054/Z949	Red or white cell or platelet survival	63.80	20.70	10.30
Z055/Z950	Red or white cell or platelet survival and serial surface counts	99.20	27.60	13.80
Musculoskeletal System				
Z065/Z961	Whole body survey — bones, joints, soft tissue, marrow	85.00	30.50	15.20
Z049/Z962	Specific site — one or more	56.70	22.30	11.20
Z038/Z958	Whole body ⁶⁷ Gallium or radioactive indium scanning	106.30	33.20	16.60
Z039/Z959	⁶⁷ Gallium scanning or radioactive indium specific site	77.90	23.10	12.00
Z056/Z984	Bone mineral density by Gamma ray scattering	22.70	6.70	6.70
Z092/Z985	Total body calcium	—	13.95	7.00
Note:	Z065/Z961 and Z049/Z962 are not to be billed together. Z007/Z926 may be billed in addition to Z065/Z961 or Z049/Z962 for blood pool study.			

NUCLEAR MEDICINE — IN VIVO

Code	- Cont'd	T \$	P ₁ \$	P ₂ \$
Nervous System				
Z064/Z979	Cerebral spinal fluid circulation	90.70	37.00	18.50
	Brain scan			
Z036/Z957	— one view only	31.90	11.40	6.20
Z066/Z963	— more than one view	63.80	22.80	12.30
Respiratory System				
	Lung scan			
Z041/Z935	— one view only	31.90	11.90	5.00
Z071/Z967	— more than one view	63.80	23.80	9.90
Z059/Z968	— ventilation and perfusion on same day ..	95.70	36.10	18.10
Miscellaneous				
Z091/Z980	Lymphangiogram	63.80	22.30	11.20
Z072/Z969	Ocular tumour localization	45.35	38.30	6.70
Z087/Z976	Tear duct — unilateral	56.70	16.65	8.30
Z085/Z989	— bilateral	63.80	19.80	9.90
Z033/Z986	Whole body counting	—	13.80	6.90

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC NUCLEAR MEDICINE PROCEDURES

Such procedural benefits are intended for the professional service of placing an instrument or introducing diagnostic radiopharmaceuticals. They are not intended to be used for simple subcutaneous, intramuscular or intravenous injection nor for oral administration. Rather than double listing the procedures and benefits in this part of the schedule, physicians are directed to the following reference points in the schedule.

- (a) Intravenous injection for peripheral venography — G376 or G379 on page 99.
- (b) Intra-articular injections — G370 on page 98.
- (c) Injection into CSF spaces or shunt apparatus — Z821 on page 217.
- (d) Arterial puncture — G479 on page 89.
- (e) Paracentesis in conjunction with shunt patency study—Z590 on page 189.

NUCLEAR MEDICINE — IN VITRO (See Radioassays under Laboratory Medicine)

RADIATION ONCOLOGY (THERAPEUTIC RADIOLOGY)

Code RADIOTHERAPY (including Therapeutic Isotopes)

\$

The listed benefits are for the professional services of a certified therapeutic radiologist, the services of a specialist for the intracavitary or interstitial application of radium or sealed sources and the services of a specialist using non-sealed sources of radioisotopes in a laboratory authorized by the Atomic Energy Control Board of Canada. Other medical services to the patient are not included in these figures. The cost of material is additional.

TELERADIOTHERAPY

Note: Paid only to a certified therapeutic radiologist, (Spec. code 34).
The fee for all inpatient services is a hospital charge.

X301	Major treatment planning (150 KVP or higher), dosage calculation and preparation of any special treatment device	39.00
X302	Teleradiotherapy — x-ray, 151 KVP or higher, radium, cobalt, cesium betatron linear accelerator — charge per treatment visit	9.90
X304	Minor teleradiotherapy — x-ray, 150 KVP or less — charge per treatment visit	6.55
Note:	For minor teleradiotherapy administered by other than certified therapeutic radiologists, use the listing under Diagnostic and Therapeutic Procedures.	

RADIUM AND RADIOISOTOPES (sealed sources)

X322	Treatment planning, dosage calculation and preparation of any special treatment device	39.00
	Intracavitary application of radium or sealed sources including dilatation and curettage carried out at same time as application	
X323	— first application	113.40
X334	— repeat application within 30 days	56.70
X324	Interstitial application of radium or sealed radioisotope	113.40
X325	Application of radium or radioisotope plaque or mould	35.40

RADIATION ONCOLOGY (THERAPEUTIC RADIOLOGY)

Code	RADIOISOTOPES (non-sealed sources)	\$
Note:	The following benefits include treatment planning, dosage calculation and preparation of materials. Appropriate visit and procedural benefits (e.g. paracentesis) may be claimed in addition. Thyroid benefits (X326, X327, X335) include administrations within any three month period.	
X326	Thyroid malignancy	51.40
X336	Prostate malignancy	46.80
X327	Hyperthyroidism	46.80
X335	Induction of hypothyroidism	46.80
X328	Polycythaemia	27.30
X329	Metastatic disease of bone	42.50
X330	Ascites and/or pleural effusion(s) due to malignancy	33.30
X332	Arthritis — single or multiple site	22.00
X333	Metastatic disease with radioactive lymphogram	33.30

DIAGNOSTIC RADIOLOGY

Column T — The benefit for radiological examination including the production of radiographs, supplying of contrast media, apparatus; premises, technical services, administration and collection costs.

Column P — The benefit for consultation between radiologist and referring physician, fluoroscopy, interpretation of radiographs and fluoroscopic findings and supervision of x-ray services by a radiologist.

From 1980 to 1982 OHIP paid a surcharge on the technical fees to private radiology clinics in recognition of the increase in film cost.

Hospital out-patient technical fees will be paid at 94.17% of the technical fee listed in the Schedule of Benefits.

Notes and Interpretations:

1. Private offices and hospital outpatient departments will claim the sum of Columns T plus P.
2. Radiologists should use Column P as a guideline for negotiating remuneration with hospitals.
3. Benefits for clinical procedures related to x-ray examination are listed in the following section, or under Diagnostic and Therapeutic or Surgical Procedures. "Clinical Procedures", in this context, are those by which contrast media are introduced, except oral or rectal administration for study of the alimentary tract, and intravenous injections, which are an integral part of the study, performed by the physician collecting the benefit for the procedure.
4. If less than the minimum number of views are performed, reduce listed benefits by 25% (this reduction applies to both technical and professional component). If more than the minimum number of views are performed, no further benefit is applicable unless specifically listed.
5. If the examinations which are requested by the referring physician yield abnormal findings or if they would yield information which in the opinion of the radiologist would be insufficient, governed by the needs of the patient and the requirements of the referring physician, the radiologist may add further views and claim for them (if listed).
6. Claims for X-ray services, when referred by an Osteopath, Chiropractor or Chiropractor to a private X-ray facility are not benefits of O.H.I.P.
7. Claims for X-ray services, when referred by an Osteopath or Chiropractor to a hospital outpatient department are benefits.
8. Coding
 - When coding the total benefit use suffix A.
 - When coding the technical portion only use suffix B.
 - When coding the professional portion only use suffix C.
 - When coding claims from certified radiologists (33) use the listed codes (i.e. X001-X230) plus the appropriate suffix.
 - When coding claims from non-certified radiologists increase the first numerical digit in the listed codes by 5 (i.e. X501-X730) plus the appropriate suffix.

DIAGNOSTIC RADIOLOGY

9. When a radiologist is asked to x-ray one extremity only, no additional claim should be made for comparison x-rays initiated by the radiologist.

10. Nephrotomography is covered by the listings for intravenous pyelogram and planigram.

11. A stereo pair is to be counted as two views.

12. No extra claim should be made for rapid sequence I.V.P.

13. No additional claim is warranted for the use of the image intensifier in diagnostic radiology.

14. Fluoroscopy claims should not be submitted for any examination performed by the radiologist where "fluoroscopy" is generally regarded as an integral part of the examination, e.g. examinations of the G.I. tract, urinary tract, special procedures.

15. "Colon — air contrast" may be claimed when performed according to generally accepted criteria. The colon should be scrupulously prepared. Five to eight full size views of the abdomen should be obtained after fluoroscopically controlled introduction of air and barium.

16. "Oesophagus, stomach and duodenum, double contrast" presupposes the introduction of gas, the use of antifoam agent and a suitable barium mixture.

17. Abdomen and chest studies should not be routinely done and claimed in gastrointestinal examinations.

18. Three or more views of the chest should not be done routinely and claimed when a chest examination is requested.

19. Chest studies should not be routinely done and claimed in mammography cases.

20. Nasal bones or accessory nasal sinuses should not be routinely claimed in skull examination requests.

21. Abdomen and/or pelvis should not be routinely claimed in lumbar spine examination requests.

22. A survey film of the abdomen is a single view. The ordering of additional films should be left to the discretion of the radiologist who should determine which examination is adequate for a specific patient. Obviously, if progress of a long tube is being followed, a survey film is sufficient. If, however, an intestinal obstruction is being followed, a single film is usually inadequate.

23. Conventional films of the spine should not be routinely done and claimed before myelography. The necessity of having plain film studies of the spine prior to interpreting the myelographic studies is obvious. It is not essential, however, that these be done at the institution where the myelogram was done. If they had been done at an outside office, then it is a matter for the radiologist and the referring physician to have the films available. If they cannot be made available to the radiologist, it is an acceptable practice for him to do the required examination of these areas and to claim for them so that they may be available for interpretation along with the myelographic study.

24. Pharynx and oesophagus (cine or videotape) — X106 should not be claimed routinely with X108 and X109 but only when specifically indicated.

DIAGNOSTIC RADIOLOGY

25. Lumbar or lumbosacral spine (X028, X205, X206) does not include the entire sacrum. However, an examination of the sacrum may be carried out and claimed only when specifically indicated.

26. The listed benefits apply to unilateral examinations except for central structures or as otherwise specified.

Code		T		P	
		Spec.	Non Spec.	Spec.	Non Spec.
		\$	\$	\$	\$
HEAD AND NECK					
X001	Skull — four views	22.70	17.00	7.40	5.60
X009	— five or more views	28.30	21.25	9.20	6.90
X003	Sella Turcica (when skull not examined)	11.30	8.50	3.60	2.70
X004	Facial bones — minimum of three views	16.50	12.40	5.80	4.40
X005	Nose — minimum of two views	11.30	8.50	3.60	2.70
	Mandible (Uni or bilateral) (not to be charged with X007)				
X006	— Minimum of three views	16.50	12.40	5.80	4.40
X012	— Four or more views	22.70	17.00	7.40	5.60
	Temporomandibular joints (not to be charged with X006 or X012)				
X007	— minimum of four views including open and closed mouth views	16.50	12.40	5.80	4.40
X008	Sinuses — minimum of three views	16.50	12.40	5.80	4.40
X010	Mastoids — bilateral — minimum of six views	21.80	16.40	8.10	6.10
X011	Internal auditory meati (when skull not examined)	16.50	12.40	5.80	4.40
N.C.	Teeth, up to ¼ set	N.A.B.	N.A.B.	N.A.B.	N.A.B.
N.C.	Teeth, up to ½ set	N.A.B.	N.A.B.	N.A.B.	N.A.B.
N.C.	Teeth, full set	N.A.B.	N.A.B.	N.A.B.	N.A.B.
N.C.	Teeth, bite wing	N.A.B.	N.A.B.	N.A.B.	N.A.B.
X016	Eye, for foreign body	11.30	8.40	5.20	3.90
X017	Eye, for localization, additional	11.65	8.75	13.25	9.90
X018	Optic foramina	12.75	9.60	5.20	3.90
X019	Salivary gland region	10.45	7.80	4.40	3.30
X020	Neck for soft tissues — minimum of two views	10.45	7.80	4.40	3.30
Spine and Pelvis					
X025	Cervical spine — two or three views	19.70	14.70	4.40	3.30
X202	— four or five views	25.30	19.00	6.00	4.50
X203	— six or more views	30.70	23.00	7.40	5.50
X027	Thoracic spine — two views	18.10	13.50	4.40	3.30
X204	— three or more views	23.70	17.75	5.90	4.40
Lumbar or lumbosacral spine					
X028	— two or three views	19.70	14.70	4.40	3.30
X205	— four or more views	25.30	19.00	6.00	4.50
X206	— six or more views	30.80	23.10	7.40	5.60

DIAGNOSTIC RADIOLOGY

Code		T		P	
		Spec.	Non Spec.	Spec.	Non Spec.
		\$	\$	\$	\$
SPINE AND PELVIS - Cont'd					
X032	Entire spine — (scoliosis series) minimum of four views	40.80	30.60	11.70	8.75
	— Orthoroentgenogram (3 foot film)				
X033	— Single view	16.50	12.40	5.80	4.40
X031	— Two or more views	22.70	17.00	7.30	5.50
X034	Sacrum and/or coccyx — two views	19.00	14.20	3.60	2.70
X207	— three or more views	23.70	17.75	5.90	4.40
X035	Sacro-iliac joints — two or three views	16.50	12.40	5.80	4.40
X208	— four or more views	22.10	16.50	7.30	5.50
X036	Pelvis and/or hips — one view	11.30	8.50	3.60	2.70
X037	— two views (e.g. A.P. and frog view; both hips; A.P. both hips plus lateral one hip)	21.15	15.90	5.10	3.90
X038	— three or more views (e.g. pelvis and sacro-iliac joints; A.P. both hips plus lateral each hip)	24.20	18.20	5.80	4.40
Upper Extremities					
X045	Clavicle — two views	11.30	8.50	3.60	2.70
X209	— three or more views	17.40	13.10	5.10	3.80
	Acromioclavicular joints (bilateral) with or without weighted distraction				
X046	— two views	16.50	12.40	5.80	4.40
X210	— three or more views	22.60	16.90	7.30	5.50
	Sternoclavicular joints — (bilateral)				
X047	— two or three views	13.60	10.20	4.40	3.30
X211	— four or more views	19.60	14.70	5.90	4.40
X048	Shoulder — two views	13.60	10.20	4.40	3.30
X212	— three or more views	19.60	14.70	5.90	4.40
X049	Scapula — two views	13.60	10.20	4.40	3.30
X213	— three or more views	19.60	14.70	5.90	4.40
	Humerus — including one joint				
X050	— two views	11.30	8.50	3.60	2.70
X214	— three or more views	17.40	13.10	5.10	3.80
X051	Elbow — two views	11.30	8.50	3.60	2.70
X215	— three or four views	17.40	13.10	5.10	3.80
X216	— five or more views	23.50	17.60	6.55	4.90
	Forearm — including one joint				
X052	— two views	11.30	8.50	3.60	2.70
X217	— three or more views	17.40	13.10	5.10	3.80
X053	Wrist — two or three views	11.30	8.50	3.60	2.70
X218	— four or more views	17.40	13.10	5.10	3.80
X054	Hand — two or three views	11.30	8.50	3.60	2.70
X219	— four or more views	17.40	13.10	5.10	3.80
X055	Wrist and hand — three views	16.50	12.40	7.30	5.50
X220	— four or more views	21.00	15.80	8.75	6.55

DIAGNOSTIC RADIOLOGY

Code		T		P	
		Spec.	Non Spec.	Spec.	Non Spec.
		\$	\$	\$	\$
UPPER EXTREMITIES - Cont'd					
X056	Finger or thumb — two views	8.75	6.55	2.55	1.90
X221	— three or more views	11.30	8.50	3.60	2.70
	LOWER EXTREMITIES				
X060	Hip — unilateral — two or more views	18.10	13.50	4.40	3.30
	Femur — including one joint				
X063	— two views	11.30	8.50	3.60	2.70
X223	— three or more views	17.40	13.10	5.10	3.80
	Knee (including patella)				
X065	— two views	11.30	8.50	3.60	2.70
X224	— three or four views	17.40	13.10	5.10	3.80
X225	— five or more views	23.50	17.60	6.55	4.90
	Tibia and fibula (including one joint)				
X066	— two views	11.30	8.50	3.60	2.70
X226	— three or more views	17.40	13.10	5.10	3.80
X067	Ankle — three views	11.30	8.50	3.60	2.70
X227	— four or more views	17.40	13.10	5.10	3.80
X068	Calcaneus — two views	11.30	8.50	3.60	2.70
X228	— three or more views	17.40	13.10	5.10	3.80
X069	Foot — three views	11.30	8.50	3.60	2.70
X229	— four or more views	17.40	13.10	5.10	3.80
X072	Toe — two views	8.75	6.55	2.55	1.90
X230	— three or more views	11.30	8.50	3.60	2.70
X064	Leg length studies (Orthoroentgenogram)	16.50	12.40	5.80	4.40
	Skeletal Surveys				
	Skeletal survey for bone age				
X057	— single film	11.30	8.50	3.60	2.70
X058	— two or more films or views	16.65	12.50	5.90	4.40
	Other survey studies — e.g., rheumatoid, metabolic or metastatic				
X080	— basic	5.60	4.20	1.80	1.40
X081	— plus per film or view	5.60	4.20	1.80	1.40
	Chest				
N.C.	Miniature chest film — for survey purposes only	N.A.B.	N.A.B.	N.A.B.	N.A.B.
X090	Single film (see Interpretation #17)	11.30	8.50	3.60	2.70
X091	Two views	16.65	12.50	5.90	4.40
X092	Three or more views	21.40	16.10	7.00	5.20
X039	Ribs (unilateral) — two or more views	13.60	10.20	4.40	3.30
X040	Sternum — two or more views	13.60	10.20	4.40	3.30
X096	Thoracic inlet — two or more views	11.30	8.50	3.60	2.70
	Abdomen				
X100	Single view (See Interpretation #17)	11.30	8.50	3.60	2.70

DIAGNOSTIC RADIOLOGY

Code		T		P	
		Spec.	Non Spec.	Spec.	Non Spec.
		\$	\$	\$	\$
X101	ABDOMEN - Cont'd Two or more views	17.40	13.00	5.10	3.90
	G.I. Tract				
X105	Palatopharyngeal analysis (cine or videotape)	22.50	16.80	14.60	11.00
X106	Pharynx and oesophagus (cine or videotape)	22.50	16.80	14.60	11.00
Note:	X106 may not be claimed with X107. It may be claimed with X104, X108, X109 only when specifically indicated. See Interpretation #24.				
X107	Oesophagus — when X103, X104, X108 or X109 not claimed	20.30	15.20	9.45	7.10
X108	Oesophagus, stomach and duodenum (including survey film, if taken)	35.30	26.50	17.00	12.75
X104	Oesophagus, stomach and duodenum (including survey film, if taken) — double contrast	36.70	27.60	18.60	13.95
X103	Oesophagus, stomach and duodenum (including survey film, if taken) — double contrast, plus small bowel	46.40	34.80	23.60	17.70
X109	Oesophagus, stomach and small bowel	45.00	33.70	22.00	16.50
X110	Hypotonic duodenogram	30.00	22.50	14.60	11.00
X111	Small bowel only	20.30	15.20	9.45	7.10
X112	Colon — barium enema (including survey film, if taken)	36.80	27.60	15.40	11.50
X113	Colon — air contrast, primary or secondary, including survey film if taken	46.50	34.90	20.00	15.00
X114	Gallbladder (one or multiple day examinations)	22.70	17.00	7.40	5.60
X120	Gallbladder (one or multiple day examinations with preliminary plain film)	30.25	22.70	7.40	5.60
X116	T-Tube cholangiogram	16.50	12.40	5.80	4.40
X117	Operative cholangiogram	16.50	12.40	5.80	4.40
X118	Intravenous Infusion cholangiogram	37.70	28.30	13.20	9.90
X123	Operative pancreatogram or E.R.C.P.	16.50	12.40	5.80	4.40
	G.U. Tract				
X129	Retrograde pyelogram (uni or bilateral)	16.50	12.40	5.80	4.40
X130	Intravenous pyelogram including preliminary film	37.70	28.30	14.70	11.00
X137	Cystogram (catheter)	18.10	13.60	4.40	3.30
X135	Cystourethrogram, stress or voiding (catheter)	21.00	15.80	8.80	6.60
X131	Cystourethrogram (non-catheter)	4.40	3.30	3.00	2.20
X191	Intestinal conduit examination or nephrostogram	16.50	12.40	5.80	4.40
X138	Percutaneous antegrade pyelogram	16.50	12.40	5.80	4.40
X139	Percutaneous nephrostomy	16.50	12.40	5.80	4.40
X134	Urethrogram (retrograde)	13.60	10.20	4.40	3.30
X136	Vasogram	13.60	10.20	4.40	3.30

DIAGNOSTIC RADIOLOGY

Code		T		P	
		Spec.	Non Spec.	Spec.	Non Spec.
		\$	\$	\$	\$
Obstetrics and Gynaecology					
X143	Survey film	11.30	8.50	3.60	2.70
X144	Pelvimetry	16.50	12.40	5.80	4.40
X145	Placentogram	16.50	12.40	5.80	4.40
X146	Any combination of above	28.55	21.40	8.80	6.60
X147	Hysterosalpingogram	22.70	17.00	7.30	5.50
X148	Intra-uterine foetal transfusion — radiological control	30.00	22.50	14.60	11.00
Fluoroscopy — by physician with or without spotfilms					
X195	Chest	7.10	5.30	7.30	5.50
X196	Skeleton	7.10	5.30	7.30	5.50
X197	Abdomen	7.10	5.30	7.30	5.50
X189	Fluoroscopic control of clinical procedures done by another physician per ¼ hour	5.60	4.20	12.30	9.20
Special Examinations					
X155	Abdominal or pelvic pneumogram	30.40	22.80	7.30	5.50
	Angiography				
	— by catheterization				
	— abdominal, thoracic, cervical or cranial				
	— using single films				
X179	non-selective	22.70	17.00	7.30	5.50
X180	selective (per vessel to a max. of 4)	30.00	22.50	14.60	11.00
	— using film changer or Cine				
X181	non-selective	45.35	34.00	14.60	11.00
X182	selective (per vessel to a max. of 4)	60.40	45.30	22.00	16.50
	Carotid angiogram — direct puncture				
X160	— unilateral	37.20	27.90	22.00	16.50
X161	— bilateral	59.90	44.90	33.10	24.80
	Peripheral angiogram				
X174	— unilateral	22.70	17.00	7.30	5.50
X175	— bilateral	30.00	22.50	14.60	11.00
X198	Splenoportogram	45.00	33.70	14.60	11.00
X199	Translumbar aortogram	45.00	33.70	14.60	11.00
	Vertebral angiogram — direct puncture or retrograde brachial injection				
X132	— unilateral	37.20	27.90	22.00	16.50
X133	— bilateral	60.90	45.70	33.10	24.80
X156	Arthrogram	20.00	15.00	16.15	12.10
X200	— with fluoroscopy and complete positioning throughout by physician	28.10	21.00	23.60	17.60
X157	Bone density (mineral content) measurement	25.50	17.00	11.70	8.75

DIAGNOSTIC RADIOLOGY

Code	SPECIAL EXAMINATIONS - Cont'd	T		P	
		Spec.	Non Spec.	Spec.	Non Spec.
		\$	\$	\$	\$
X158	Bronchogram — unilateral	22.35	16.75	14.60	11.00
X159	— bilateral	29.70	22.25	22.00	16.50
X162	Cerebral stereotaxis	45.35	34.00	14.50	11.00
X122	Cholangiogram, percutaneous trans-hepatic	22.50	16.90	11.00	8.20
X188	Computed tomography — one or more cuts, with or without contrast medium	—	—	49.35	—
X151	Cordotomy, percutaneous	37.20	27.90	22.00	16.50
X163	Dacrocystogram	22.70	17.00	7.30	5.50
X164	Discogram(s) — one or more levels	22.35	16.75	14.60	11.00
X167	Fistula or sinus injection	16.50	12.40	5.80	4.40
X169	Laminogram, planigram, tomogram	30.40	22.80	7.30	5.50
X170	Laryngogram	22.35	16.75	14.60	11.00
X171	Lymphangiogram	37.70	28.20	14.60	11.00
X192	Mammary ductography	16.50	12.40	5.80	4.40
X184	Mammogram — unilateral	18.90	14.20	8.10	6.05
X185	— bilateral	28.10	21.00	12.10	9.10
	— using xeroradiography				
X186	— unilateral	23.30	17.50	8.10	6.05
X187	— bilateral	35.85	26.90	12.10	9.10
X150	Mechanical evaluation of knee	19.40	14.60	10.30	7.70
X193	Microradioscopy of the hands	11.40	8.40	7.30	5.50
X173	Myelogram (spine and/or posterior fossa)	26.70	20.00	17.60	13.20
X190	Pantomography	13.60	10.20	4.40	3.30
X154	Penis	12.20	9.10	2.90	2.20
X176	Sialogram	22.70	17.00	7.30	5.50
X177	Skin thickness measurement	11.90	9.00	5.80	4.40
X183	Ventriculogram or pneumoencephalogram	37.20	27.90	22.00	16.50
X165	Photographic subtraction	—	—	7.10	—
X166	Examination using portable machine in home add	48.00	48.00	—	—
Note:	This code does not apply to the use of a portable machine in a hospital. Can only be claimed once per day regardless of the number of people x-rayed in the same home.				

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

- Note:**
1. These procedural benefits are intended to cover compensation for the professional service of placing an instrument and, if done, of introducing contrast media (except oral or rectal administration for study of the alimentary tract). Injection of materials to enhance the effect of contrast media is included in the procedure benefits.
 2. Radiological charges are additional: see similar entries under section on RADIOLOGY.
 3. Where similar procedures are done for diagnostic physiological studies of non-radiological nature, e.g. cardiac catheterization or intra-arterial infusion, they are listed separately under Surgery or Diagnostic and Therapeutic Procedures. See Index.

Code	Angiography	Spec.	Anaes.
		\$	
	— by catheterization		
	— abdominal, thoracic, cervical or cranial		
J021	Insertion of catheter (including cut down if necessary) and injection, if given	68.00	5
J022	Selective catheterization — add to catheter insertion benefit (per vessel to maximum of four) each	34.00	
Note:	J021 includes insertion to any distance along vessel and its extensions. J022 applies only when selected branches are catheterized.		
J014	Selective catheterization (spinal and parathyroid angiography — add to benefit for catheter insertion (per vessel) each	17.00	
	("Selective" means manipulation of the catheter from the vessel of introduction into a branch, tributary, or cardiac chamber with angiogram(s))		
J031	Carotid angiogram — direct puncture	54.20	5
J025	Transluminal angioplasty — including angioplasty with or without pressure measurements — one or more sites or vessels	177.15	5
J048	Percutaneous trans-hepatic catheter portal venography . .	138.20	
J027	Peripheral arteriogram — direct puncture	34.00	4
J026	Peripheral venogram — direct puncture	27.30	4
	Selective coronary catheterization including angiogram — see G293, G297 on page 90		
J033	Splenoportogram	54.20	4
J034	Trans-lumbar aortogram	54.20	4
J032	Vertebral angiogram — direct puncture or by retrograde brachial injection	54.20	5

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

Code		Spec.	Anaes.
		£	
	Embolization e.g. for treatment of hemangioma or renal carcinoma		
J040	— first vessel, claim appropriate angiographic procedural and radiological benefits plus	46.80	
J047	— each additional vessel catheterized and occluded, per vessel	22.00	
J023	Intra-arterial infusion of drugs e.g. for control of gastrointestinal haemorrhage — claim appropriate angiographic procedural and radiological benefits plus a per diem supervision benefit of	13.10	
J035	Pressure measurements during angiography	13.10	
J001	Arthrogram	13.10	4
	Biliary duct calculus manipulation etc. — see Z562 on page 188.		
J024	Bronchial brushing — unilateral	54.20	6
J044	— bilateral	81.30	6
J002	Bronchogram — unilateral	16.20	6
J043	— bilateral	24.40	6
J003	Bronchogram with intra-tracheal catheter — unilateral	33.10	6
J042	— bilateral	49.60	6
J050	Carotid or vertebral artery occlusion by detachable balloon — percutaneous	148.80	
J005	Dacrocystogram	20.20	4
J006	Discogram — one disc	46.80	4
J030	— each additional disc	24.10	
J049	Embolization of spinal arteriovenous malformation — percutaneous	212.60	
J036	Fistula or sinus injection	13.10	
J008	Hysterosalpingogram	27.30	4
J004	Intramammary needling for localization under mammographic control	20.20	
	Intubation of small intestine — see Z540 on page 184.		
J009	Laryngogram	16.30	
J010	Lymphangiogram — per side	46.80	
J037	Mammary ductography	20.20	
J011	Myelogram	46.80	4
J038	— with supine views requiring removal and re-introduction of spinal needle, add	13.10	
J020	— with posterior fossa views, add	13.10	
J012	Nephrotomogram	—	4
J045	Percutaneous antegrade pyelogram	54.20	4
J046	Percutaneous nephrostomy	99.20	4
J041	Percutaneous removal of intravascular foreign bodies	I.C. I.C.	
J051	Percutaneous spinal cord puncture for syringogram	46.05	4
J013	Percutaneous trans-hepatic cholangiogram	46.80	4
J015	Peritoneal pneumogram	20.20	4

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

Code		Spec.	Anaes.
		\$	
J016	Pneumoencephalogram	60.20	5
J052	Positive contrast cisternogram	60.20	4
J017	Presacral insufflation	34.00	4
J039	Renal cyst puncture	54.20	4
J018	Sialogram	20.20	4
J007	Tomogram	—	4
J028	Urethrogram, urethrocystogram, or intestinal conduit examination, nephrostogram, cystogram	13.10	
J029	Vasogram	36.10	4



PULMONARY FUNCTION STUDIES

Column T — The benefit for testing including supplying of equipment, premises and technical services.

Column P — The benefit for professional services including responsibility for quality control and technician training, interpretation of the results of the tests, and consultation between the physician responsible for the tests and the referring physician concerning the results of the tests.

- Notes:**
- (1) The total benefit is obtained by adding columns T and P together.
 - (2) Coding: When coding the total benefit, use suffix A.
When coding the technical portion only, use suffix B.
When coding the professional portion only, use suffix C.
 - (3) The benefits for simple spirometry and standard lung mechanics represent the best of three recorded tests results with or without bronchodilator.
 - (4) The following tests are considered to be specific and require the individual ordering notation for each test parameter.
 - (5) The benefit for standard lung mechanics includes simple spirometry.
 - (6) Vital capacity and flow volume loop cannot be claimed at the same time.

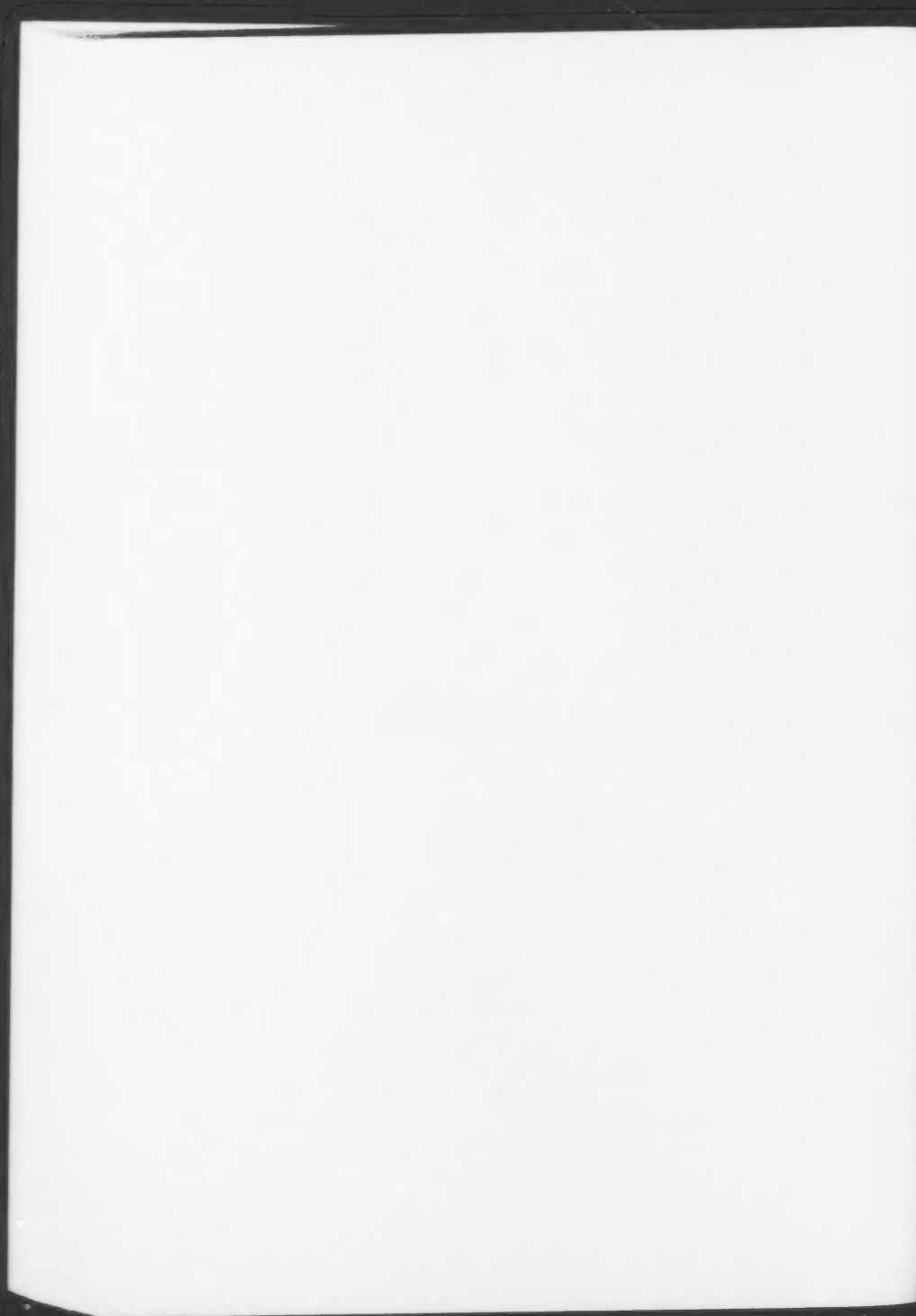
Code		T	P
		\$	\$
	Simple Spirometry e.g. vital capacity, without permanent record by transducer equipment		
J300	1. FVC, FEV ₁ , MVV (MBC) etc.	2.20	1.50
	Standard Lung Mechanics (with permanent record)		
J301	2. (a) Vital capacity, FEV ₁ , FEV ₁ /FVC	9.20	4.60
J324	(b) Repeat 2(a) after bronchodilator	1.80	1.80
J325	(c) Same as 2(a) plus MMEFR calculation	9.60	6.30
J326	(d) Repeat 2(c) after bronchodilator	1.80	1.80
J302	(e) MVV done together with 2a, 2c	.80	.80
	2(a) and 2(c) cannot be billed together		
	2(b) and 2(d) cannot be billed together		
J304	3. (a) Flow volume loop (FVC, FEV ₁ , FEV ₁ /FVC, V ₃₀ , V ₂₅) ..	13.80	8.90
J327	(b) Repeat 3(a) after bronchodilator	1.80	1.80
	Complex Lung Mechanics		
J311	4. (a) Functional residual capacity by gas dilution method	11.05	7.15
J307	(b) Functional residual capacity by body plethysmography ..	12.00	7.15
J306	(c) Airways resistance by plethysmography or estimated using esophageal catheter	11.05	6.30

PULMONARY FUNCTION STUDIES

Code		T \$	P \$
J305	5. Lung Compliance (pressure volume curve of the lung from TLC to FRC)	35.85	30.40
J309	6. (a) Carbon monoxide diffusing capacity by steady state at rest	8.20	6.20
J310	(b) Single breath diffusing capacity	14.70	7.40
J308	7. Pulmonary Function Response to O ₂ and CO ₂		
J328	(a) CO ₂ ventilatory response	13.80	9.20
	(b) O ₂ ventilatory response (physician must be present)	13.80	13.80
	Exercise Assessment — physician must be in attendance at all times.		
J314	8. Exercise diffusing capacity	6.20	9.40
J315	9. (a) Stage I: Graded exercise to maximum tolerance exercise (must include continuous heart rate and ventilation at rest and at each workload)	34.30	22.85
E450	(b) — plus 2a, 2c or 3a before and/or after exercise, add	9.20	4.60
E451	(c) — plus 12 lead E.C.G. done at rest, used for monitoring during the exercise and followed for at least 5 minutes post exercise, add	12.50	14.40
J316	(d) Stage II: Repeated steady state graded exercise (must include heart rate, ventilation, VO ₂ , VCO ₂ , BP, ECG, end tidal and mixed venous CO ₂ , at rest, 3 levels of exercise and recovery)	90.20	42.30
J317	(e) Stage III: Same as 9c plus arterial blood gases, PH and bicarbonate or lactate	119.70	71.80
J330	(f) Exercise induced asthma assessment (Workload sufficient to achieve a HR of 85% of max.; measurement of 2a, 2c or 3a before exercise and 5-10 minutes post exercise	23.00	13.80
	Gas Analysis		
G479	10. (a) Arterial puncture for blood gas analysis	—	6.20
J319	(b) Blood gas analysis: pH, PO ₂ , PCO ₂ , bicarbonate and base excess	8.30	—
J318	(c) Arterialized venous blood sample collection (e.g. ear lobe)	2.80	—
J320	(d) A-a oxygen gradient (measurement of RQ by sampling mixed expired gas and using alveolar air equation)	15.20	7.80
J331	(e) Estimate of shunt (Qs/Qt) breathing pure oxygen	20.30	10.20
J313	(f) Mixed venous PCO ₂ by the rebreathing method	8.30	2.80
J323	(g) O ₂ saturation by oximeter (at rest)	8.00	4.00
J332	(h) — same as 10(g) with measurements at rest and exercise	12.00	6.00
J322	(j) Standard O ₂ consumption and CO ₂ production	20.30	5.10
J333	11. Histamine or methylcholine threshold test	26.30	13.80
J335	12. Antigen challenge test	36.80	18.40

PULMONARY FUNCTION STUDIES

Code	Sleep Apnea (Overnight) Study — special visit premiums not chargeable in addition	T	P
		\$	\$
	13. Monitoring of oxygen saturation and ventilation for a period of sleep time.		
J339	(a) to include physician attendance at set-up, monitoring and interpretation	—	85.00
J336	(b) interpretation only	—	31.90
	14. Same as (13), with additional monitoring such as to allow the staging of sleep, e.g., EEG, EOG.		
J337	(a) to include physician attendance at set-up, monitoring, and interpretation, add to J339 when performed	—	31.90
J338	(b) interpretation only, add to J336 when performed	—	12.75



DIAGNOSTIC ULTRASOUND

- Notes:**
- (1) T and P Columns should be interpreted in the spirit of the first two paragraphs on page 63, but without limiting the performance of these tests to physicians of any one specialty.
 - (2) The total benefit is obtained by adding columns T and P together.
 - (3) Coding: When coding the total benefit, use suffix A.
When coding the technical portion only, use suffix B.
When coding the professional portion only, use suffix C.
 - (4) A-Mode — implies a one-dimensional ultrasonic measurement procedure.
 - (5) M-Mode — implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures.
 - (6) Scan B-Mode — implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display.
 - (7) All ultrasound examinations include a permanent record and interpretation.

Code		T	P
		\$	\$
J100	Head and Neck Echoencephalography-midline, A-mode	—	3.50
J122	Brain — complete, B-mode	33.80	19.50
J102	Echography-ophthalmic (excluding vascular study) Quantitative, A-mode	17.70	25.90
J103	B-scan immersion	34.70	34.40
J107	B-scan contact	17.50	17.00
J108	Biometry (Axial length-A-mode)	17.40	23.00
Note:	J102, J103, J107, J108 — for bilateral procedures, add 50% of the listed benefit.		
J105	Face and/or neck (excluding vascular study)	33.80	19.50
	Heart		
J118	Echocardiography — complete study — 1 dimension	27.30	27.30
J120	— 2 dimensions (real time)	46.80	42.90
J121	— 1 and 2 dimensions at same patient visit	60.05	56.90
J119	— limited study — 1 or 2 dimensions for follow up studies ..	12.90	12.90
	Thorax		
J125	Chest masses, pleural effusion-A & B-mode	33.80	19.50
	Abdomen and Retroperitoneum		
J135	Abdominal scan, complete	33.80	19.50
J128	Abdominal scan, limited study (e.g. gallbladder only, aorta only or follow up study)	22.30	12.90
	Pelvis		
J159	Pregnancy, complete	33.80	19.50
J162	Pelvic, complete	33.80	19.50
J163	Pelvis or pregnancy, limited study (e.g. fetal age determination, placental localization I.U.C.D. localization only)	22.30	12.90

DIAGNOSTIC ULTRASOUND

Code	Vascular System	T	P
		\$	\$
J190	Bilateral carotid artery evaluation — Doppler scan or B scan . .	33.80	19.50
J191	— frequency analysis	33.80	19.50
J192	— frequency analysis with scan	50.70	29.20
	Peripheral artery evaluation (including vertebral and subclavian arteries)		
J193	— Doppler scan or B scan	16.90	12.90
J194	— frequency analysis	11.30	10.60
J195	— frequency analysis with scan	24.00	20.00
J198	Venous assessment (bilateral) — includes assessment of femoral, popliteal and posterior or tibial veins with appropriate functional manouvres and permanent record (not chargeable during surgery or during the patient's post operative stay in hospital)	5.30	8.10
	Vascular laboratory fees		
J199	Ankle pressure determination — not chargeable during surgery or during the patient's post operative stay in hospital	—	6.40
J200	Ankle pressure measurements with segmental pressure recordings and/or pulse volume recordings and/or Doppler recordings	14.70	17.90
J196	Ankle pressure measurements with exercise and/or quantitative measurements added to the above	5.70	8.50
J197	Penile pressure recordings — two or more pressures	5.00	6.40
	Miscellaneous		
J180	Echography for placement of radiation therapy fields, scan B-mode	25.15	15.50
J182	Extremities — per limb (excluding vascular study)	16.90	9.80
J127	Breast — scan B-mode (per breast)	16.90	9.80
J183	Testicular scan — per testis	16.90	9.80
J149	Ultrasonic guidance of biopsy aspiration, amniocentesis or drainage procedures (one physician only)	33.80	19.50

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code With a few exceptions specifically indicated below, the listed procedural benefits are for the procedure(s) alone. Consultations or visits when such services are rendered, may be claimed in addition to the procedure(s).

G700 When a procedure(s) is the sole reason for a visit, add \$3.20 per patient visit for those procedures marked (+) regardless of the number of procedures carried out during that visit. However, if the patient visit is to a **physician's office** or a diagnostic facility controlled directly or indirectly by a physician who has examined (or is about to examine) the patient and referred the patient to such a diagnostic facility, G700 may not be claimed under these circumstances.

Note: G700 is not payable to a hospital department.

Schedule Interpretations:

1. If in the course of any office or home visit (see Preamble, Part B), a haemoglobin screen and/or haematocrit (any method or instrument) is carried out, code G481 may be claimed for this service (see page 89). Urinalysis may be claimed with or without an associated visit to a physician's office, except for screening and urinalyses which are not medically necessary (see Preamble, part A, paragraph (2)).
2. Some benefits for Diagnostic and Therapeutic Procedures have the technical and professional components listed separately. However, when only one benefit is listed for a service, it represents the professional component only. The technical component includes the salaries of support staff, equipment depreciation or lease costs, supplies and costs associated with the preparation of a written report. The professional component includes the clinical supervision of the diagnostic facility, interpretation of the test results and a written report.
3. The Preamble applicable to Surgical Procedures also applies, where appropriate, to Diagnostic and Therapeutic Procedures.

ALLERGY

Note: If, in addition to the allergy injection, the patient requires a minor assessment only of his allergic condition, the physician may claim for code G212 only. However, if a patient requires a more complete assessment of his condition or if a patient presents for an allergy injection and has an acute infectious condition, albeit of the respiratory system, or some other unrelated condition any of which would have otherwise required a separate office visit, the physician is entitled to claim for the appropriate assessment as well as the injection.

Code		Procedural	
		Fee	Anaes.
G200	Acute desensitization, e.g. ATS, penicillin	\$	5.50

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code		Procedural	
		Fee	Anaes.
	ALLERGY - Cont'd	\$	
+ G201	Direct nasal tests, \$1.10 each, maximum	3.30	
+ G202	Hyposensitization, including assessment and supervision (one or more injections)	2.50	
Note:	Use this code for rabies injection(s).		
G212	If hyposensitization is the only service rendered, use this code. This code combines G700 and G202	5.70	
G205	Insect venom desensitization (immunotherapy) — per injection to a maximum of 5 per patient per day	8.10	
Note:	In addition to G205, after the initial major assessment a minor assessment may be claimed once per day if rendered.		
G199	Insect venom skin testing provided in physician's office or hospital including physician interpretation, \$0.80 each, maximum	24.00	
+ G203	Ophthalmic tests — direct, \$1.10 each, maximum	3.30	
+ G204	— quantitative	8.50	
G206	Patch test \$0.95 each, maximum of 35 per year	33.25	
G198	Maximum of 50 per year for industrial or occupational dermatoses	47.50	
+ G207	Bronchial provocative testings — per session (limit of 6 sessions per patient)	8.85	
+ G208	Repository therapy, per injection (cost of materials extra)	8.85	
	Skin tests provided in physician's office or in hospital, including physician interpretation, (scratch or intradermal method)		
G209	— technical component \$0.53 each, maximum	26.50	
G197	— professional component \$0.07 each, maximum	3.50	

ANAESTHESIA

Examination Under Anaesthesia — when sole procedure performed not otherwise listed in the schedule (diagnosis required)

G260	with or without intubation	31.90	4
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CARDIOVASCULAR

Vascular Cannulation (including injections and cut-down, if necessary)

G268	Cannulation of artery or central vein e.g. for pressure measurement or for feeding line	19.50	
G309	Umbilical artery catheterization (including obtaining of blood sample)	28.30	
Note:	Use this code for Usher routine for acidosis (infant).		
G282	Umbilical vein catheterization (including obtaining of blood sample)	12.40	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code		Procedural	
		Fee	Anaes.
		\$	
	CARDIOVASCULAR - Cont'd		
G287	Insertion of Swan-Ganz catheter (not included in anaesthetic, respiratory or critical care benefits)	102.70	4
G304	— when dye dilution densitometry done in addition at same sitting, add		
G398	Insertion of permanent feeding line e.g. Hickman or Broviac Catheter	31.90	
G399	Surgical removal of Hickman or Broviac Catheter	85.00	4
G479	Arterial puncture	24.80	4
+ G480	Venipuncture — infant	6.20	
+ G482	— child	5.80	
+ G489	— adolescent or adult	3.90	
+ G483	Therapeutic venisection (phlebotomy)	1.40	
G271	Anticoagulant supervision — long term, telephone advice — per month	6.00	
G481	Hemoglobin screen and/or hematocrit, rendered in physician's office in conjunction with visit (any method or instrument)	7.10	
		.85	
	Blood Transfusions:		
G279	Indirect transfusion	11.70	
G275	Exchange transfusion (procedure only)	127.50	
Note:	Assistant at exchange transfusion — see Preamble, Part B, Paragraph 32(g)		
G280	Intra-uterine foetal transfusion — initial or subsequent	116.90	
G276	Plasmapheresis (to include cannulation)		
	— donor cell pheresis (platelets or leukocytes)	9.60	
	— therapeutic plasma exchange		
G277	— initial and repeat, to a maximum of 5 per year, each	47.50	
G278	— beyond 5 per year, each	23.70	
G272	Manual plasmapheresis (see Preamble, part B, paragraph 22)	I.C.	
	Cardioversion:		
G285	Cardioversion — limit of three sessions per patient, per day	35.40	5
	Cardiac Catheterization:		
	When more than one procedure is carried out at one sitting, the additional procedures are to be claimed at 50% of the listed benefits.		
G290	— pressures only	92.10	5

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code		Procedural	
		Fee	Anaes.
		\$	
	CARDIOVASCULAR - Cont'd		
	Left heart		
G291	— retrograde aortic	109.80	5
G292	— transseptal	148.80	5
G286	Cardiac electrophysiological studies (endomyocardial mapping)		
	with times pulse stress of conduction system to analyze		
	arrhythmias	159.40	5
G293	Selective coronary catheterization — both arteries	155.90	5
G263	— with drug interventional studies, add	56.70	
G265	Transluminal coronary angioplasty including angiography with or without pressure measurements, one or more sites or vessels	233.80	5
G297	Angiograms (any number of injections)	70.90	
G296	Dye dilution densitometry and/or thermal dilution studies — coronary flow index benefit covers all studies on the same day	63.80	
Note:	When G296 is done in addition to G287, it may be claimed at 50% only. Use code G304 instead.		
G298	Intracardiac electrocardiography and/or atrial pacing	63.80	
G299	Oxymetry	63.80	
G289	Fick determination	63.80	
G300	Metabolic studies, e.g. coronary sinus lactate and pyruvate determinations	63.80	
G301	Exercise studies during catheterization	70.90	
G305	Intracardiac phonocardiography	70.90	
G306	Isotope studies during cardiac catheterization	63.80	
G267	HIS bundle ECG	106.30	
G266	HIS bundle ECG, timed pulse stress of conduction with drug intervention	141.70	
G294	Insertion of temporary endocardial electrode	95.70	5
G254	Repositioning of temporary endocardial electrode	42.50	5
G295	Insertion of permanent endocardial electrode and implantation of pack (includes insertion of temporary transvenous lead at same surgical procedure by same surgeon)	194.90	5
G269	Insertion of permanent endocardial electrode(s)	88.60	
G270	Exposure of vein and implantation of pack	102.70	5
G302	Repositioning of permanent endocardial electrode (as separate procedure)	77.90	5
G264	Replacement of pack	88.60	5
G288	Endomyocardial biopsy — transvascular, right or left	106.30	
G303	Insertion of transthoracic pacemaker	31.90	4

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	CARDIOVASCULAR - Cont'd	Procedural	
		Fee	Anaes.
		\$	
	Electrocardiography: (professional component must include pertinent written interpretation)		
+ G310	E.C.G. — technical component		
G313	— professional component — practice in general	4.60	
G318	— professional component — specialist	4.60	
	Before and after exercise (Master's criteria, Levy Ischemia or Frasher Exercise test) includes complete resting tracing and multiple leads taken immediately and 3 and 6 minutes post exercise.	6.40	
G314	— technical component	7.40	
G334	— professional component	7.40	
	Maximal stress E.C.G. (exhaustion, symptoms, or E.C.G. changes) or sub-maximal stress E.C.G. (to target heart rate for patient) by a standard technique — with treadmill or ergometer and oscilloscopic continuous monitoring including E.C.G.'s taken during the procedure and resting E.C.G.'s before and after the procedure (physician must be in attendance at all times) The professional component includes the necessary clinical assessment immediately prior to testing		
G315	— technical component		
G319	— professional component	23.40	
G316	Vector — technical component	35.40	
G335	— professional component	11.70	
	Continuous ECG monitoring e.g. Holter	6.40	
	Level 1 — requires a recorder capable of recording all beats and transmitting this information to a scanner which is capable of analyzing and printing every beat and also performing trend analysis on the 12 or 24 hour tape.		
	Level 2 — requires a recorder capable of recording only a portion of each minute, or a predetermined time period after an abnormal complex is sensed. The scanner of this recorder is capable of analyzing the tape and printing all beats in the predetermined time period analyzing the ST segment, heart rate and ventricular premature beat frequency.		
	Level 3 — requires a recorder capable of recording beats for only a portion of a minute and feeding this information into a scanner through an adapter that feeds the information through the standard E.C.G. machine.		
G650	Level 1 — professional component	31.20	
G651	— technical component — recording	17.00	
G652	— scanning	23.40	
G653	Level 2 — professional component	23.40	
G654	— technical component — recording	17.00	
G655	— scanning	11.70	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code		Procedural	
		Fee	Anaes.
	CARDIOVASCULAR — Cont'd	\$	
G656	Level 3 — professional component	15.60	
G657	— technical component — recording	11.70	
G658	— scanning	7.80	
	Interpretation of telephone transmitted E.C.G. rhythm strip		
G320	— professional component must include pertinent written interpretation	2.30	
G311	— technical component for telephone transmission	1.20	
	Pacemaker reprogramming including electrocardiography		
G283	— professional component	5.80	
G284	— technical component	5.80	
	Pacemaker pulse wave analysis with electrocardiography		
G307	— professional component	5.80	
G308	— technical component	5.80	
	Non Invasive Cardiology:		
Note:	When more than one procedure of items marked (*) are performed at one sitting, the major procedure may be claimed in full and the remainder at 50% of the listed benefit(s).		
	*Phonocardiogram — multiple channel — before and after exercise (not less than 3 channels)		
G504	— professional component	11.70	
G505	— technical component	28.30	
G506	(with pharmacologic intervention), add	5.80	
G507	*Apex cardiogram — professional component	7.10	
G508	— technical component	7.10	
	Echocardiography — see Diagnostic Ultra Sound.		
	Blood Flow Study (Doppler or other) — uni or bilateral		
	*Phlebography and/or carotid pulse tracing (with systolic time intervals) — before and after exercise		
G518	— professional component	7.10	
G519	— technical component	7.10	
G502	Carotid phonoangiography — professional component	6.70	
G503	Oculoplethysmography — professional component	6.70	
	Impedance plethysmography		
G120	— professional component	4.25	
G121	— technical component	8.50	
	Peripheral Arterial and Venous System — see listings under Diagnostic Ultrasound on page 85		

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

		Procedural
		Fee Anaes.
Code	CRITICAL CARE	\$
Life Threatening Emergency Situation: — Resuscitation in emergency situation (cardiac arrest, massive injury, cardio-respiratory failure, resuscitation of newborn, severe shock, coma) includes immediate crisis related examination and usual resuscitative measures and to include as required, defibrillation, cardioversion, cut down(s), intravenous lines, pressure infusion sets and pharmacological agents, urinary catheters, arterial and/or venous catheters, C.V.P. lines, blood gases, nasogastric tubes with or without lavage, endotracheal intubation and tracheal toilet.		
G521	Benefit per physician — first ¼ hour	53.10
G522	— after first ¼ hour (per ¼ hour or major part thereof)	17.70
Other Resuscitation:		
G395	Benefit per physician — first ¼ hour	24.80
G391	— after first ¼ hour (per ¼ hour or major part thereof)	12.40
Note:	Consultations or assessments rendered before or after critical care is no longer necessary, should be claimed on a fee-for-service basis.	
G211	Endotracheal intubation for resuscitation (not to be claimed when followed by a surgical procedure)	22.70
G210	Hypothermia (therapeutic) induction and management	120.50
Hyperbaric Therapy; (per dive)		
Physician in chamber with patient(s)		
G800	— per dive, first ¼ hour	35.40
G801	— after first ¼ hour (per ¼ hour or major part thereof)	17.70
G802	— after 2 hours in chamber (per ¼ hour or major part thereof)	35.40
Physician not in chamber with patient(s)		
— per dive, charge on the basis of other Resuscitation (G395 and G391)		
Consultation(s) or assessment(s) and special visit premium(s) may be charged on a per patient basis when these services are rendered.		
Note:	G800, G801, G802 — hyperbaric therapy is not a benefit of OHIP for treatment of some conditions. Please refer to OHIP District Office for qualifying diagnoses.	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	CRITICAL CARE – Cont'd	Procedural	
		Fee	Anaes.
	Respiratory Care:		\$
	— includes examinations of the patient and (as required) includes intravenous lines; pressure infusion sets and pharmaceutical agents; insertion of arterial, C.V.P. or urinary catheters; securing and interpretation of blood gases; nasogastric tubes; endotracheal intubation with or without artificial ventilation; tracheal toilet; use of an artificial ventilator and all necessary measures for its supervision.		
	Physician-in-Charge		
G405	— 1st day		120.50
G406	— 2nd to 5th days (inclusive) per diem		53.10
G407	— 6th to 28th days (inclusive) per diem		42.50
G408	— 29th day onwards per diem		21.25
Notes:	(1) The foregoing benefits apply only to respiratory care rendered in a Respiratory Care Unit or other special care unit such as the ICU where special monitoring equipment is available. The fees under Physician-in-Charge apply per patient treated, i.e., while the physician-in-charge may change during the course of treatment, the fee formula as set out should be charged by the physicians involved as if there was only one physician-in-charge during the treatment program. (2) The appropriate consultation, procedure and visit benefits shall apply after stopping artificial respiration or special care. (3) If a patient has been discharged from the Respiratory Care Unit more than 48 hours and then is re-admitted to the Unit, the 1st day rate applies again on the day of re-admission. For re-admission less than 48 hours after discharge, the appropriate code G406-G408 should be used. (4) Other physicians apart from those providing respiratory care may claim the appropriate consultation, visit and procedure benefits not listed in the schedule for Respiratory Care. Anaesthetists rendering short duration interim care in the recovery room prior to transfer to the special care unit should submit claims in accordance with the Preamble, Part B, paragraph 33(J). Longer duration care rendered in accordance with the above definition of Respiratory Care should be considered as the applicable first day care G405.		

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code		Procedural	
		Fee	Anaes.
		\$	
	CRITICAL CARE - Cont'd		
	Neonatal Intensive Care:		
	Level A: Full life support including invasive monitoring, ventilatory support (all modalities) and parenteral alimentation		
G600	— 1st day	194.90	
G601	— 2nd to 10th days (inclusive), per diem	99.20	
G602	— 11th day onwards, per diem	49.60	
	Level B: Intensive care including full monitoring both invasive and non-invasive. Oxygen administration and intravenous therapy, but without ventilatory support		
G610	— 1st day	124.00	
G611	— 2nd day onwards, per diem	35.40	
	Level C: Intermediate care including oxygen administration, non-invasive monitoring and gavage feeding		
G620	— 1st day	88.60	
G621	— 2nd day onwards, per diem	17.70	

- Notes:**
- (1) The foregoing benefits apply only to care rendered in a Special Care Unit or a Respiratory Care Unit or the ICU where special monitoring equipment is available.
 - (2) The foregoing benefits include the initial **consultation** or assessment and subsequent examinations of the patient and, as required, insertion of arterial, venous, C.V.P. or urinary catheters, intravenous lines, interpreting of blood gases, nasogastric tubes, pressure infusion sets, pharmaceutical agents, endotracheal intubation, tracheal toilet, artificial ventilation, and all necessary measures for respiratory support.
 - (3) These are team benefits which apply to neonatologists/ paediatricians/anaesthetists providing complete care. If ventilator care, only, is provided by anaesthetist(s), the above listings do not apply. Instead, claims should be rendered under the Respiratory Care listings (G405 etc.) with neonatology paediatric components claimed on a fee-for-service basis.
 - (4) If an infant has been transferred from one level to another in either direction, up or down, the 2nd day listings apply.
 - (5) **Regular visit and procedure fees will apply the day following termination of Neonatal Intensive Care**
 - (6) **If a patient has been discharged from the Neonatal Intensive Care Unit more than 48 hours and then is readmitted to the Unit, the 1st day rate applies again on the day of re-admission. For re-admission less than 48 hours after discharge, the appropriate code G601, G602, G611 or G621 should be used.**

Intensive Care Monitoring:

- Note:** This category excludes Cardio-Pulmonary Resuscitation and Respiratory Care and should be claimed on the basis of the appropriate consultation, procedure and visit. (Also see Preamble, Part B, paragraph 20(b))

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code		Procedural	Anaes.
		Fee	
	DIALYSIS: team benefits, to include listed items. (This does not include preliminary investigation of the case.)	\$	
	Haemodialysis (to include haemofiltration, haemoperfusion)		
R849	Initial and acute (to include surgical components)	545.60	6
R850	Insertion of Cannula or Scribner shunt (to be included in the \$545.60 initial)	194.90	6
G325	Medical component (to be included in the \$545.60 initial)	350.75	
G323	Acute, repeat (maximum of 3)	177.15	
G326	Chronic each	41.10	
	Revision of Cannula or Scribner shunt		
G327	— single	63.80	4
G328	— both	95.70	4
G329	De-clotting of Cannula or Scribner Shunt	58.45	
R843	Removal of Cannula or Scribner shunt	50.70	4
G324	Insertion of subclavian catheter for haemodialysis	58.45	
G336	— revision or changing	9.60	
R851	By-pass graft for haemodialysis — synthetic	248.00	7
R840	— autogenous vein	265.70	7
R833	Ligation or removal of by-pass graft	51.40	4
R841	Obliteration of A-V fistula	51.40	4
Notes:	— For operative thrombectomy of bypass graft, use code R813, page 171.		
	— For creation of A-V fistula; use code R827, page 171.		
	Peritoneal dialysis:		
G330	Acute (up to 48 hours) includes stylette cannula insertion (temporary)	124.00	
G331	Repeat acute (up to 48 hours) — maximum of 3	113.40	
G332	Chronic (up to 48 hours) — maximum of \$116.90 per week	58.45	
R852	Insertion of peritoneal cannula by laparotomy	116.90	6
R853	Insertion of Tenckhoff type peritoneal catheter — chronic — by trocar	58.45	4
R854	Removal of Tenckhoff type peritoneal catheter	31.90	4
	Home dialysis and self-care dialysis:		
G333	Weekly retainer for administration, routine visits and supervision (plus fee for service for complications)	19.50	
	ENDOCRINOLOGY AND METABOLISM		
+G493	ACTH test — single or multiple, per injection	3.90	
+G337	Antidiuretic hormone response test including the 8 hour water deprivation test	10.60	
+G494	Glucagon test (Type A) for carbohydrate response	6.40	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

		Procedural Fee	Anaes.
Code	ENDOCRINOLOGY AND METABOLISM – Cont'd	\$	
+ G495	(Type B) for hypertension, pheochromocytoma and insulinoma provocative test (including cold pressor test)	26.60	
G358	Growth hormone exercise stimulation test with physician present (includes venipuncture(s))	15.60	
+ G340	Histamine test to include a control cold pressor test	28.30	
+ G341	Hypertonic saline infusion test	10.60	
+ G342	Implantation of hormone pellets	19.50	
+ G497	Insulin hypoglycemia pituitary function test with or without TRH and LHRH alone or in combination	31.20	
+ G498	Intravenous glucose tolerance test	6.40	
+ G499	Intravenous tolbutamide test	31.20	
+ G513	Pentagastrin stimulation for calcitonin	10.60	
+ G344	Phentolamine test	26.60	
+ G501	TRH and/or LHRH test, per injection	3.90	
+ G490	Saralasin test	26.60	
GASTROENTEROLOGY			
G349	Oesophageal tamponade (Blakemore bag) — insertion	28.30	
	Oesophageal motility study(ies) with manometry		
G350	— standard, with physician in continuous attendance	60.20	
G343	— interpretation only	12.40	
	Oesophageal pH study for reflux		
G251	— standard, with physician in continuous attendance	21.25	
G351	— with 24 hour monitoring	24.80	
G346	— tracing interpretation only	12.40	
	Oesophageal acid perfusion test		
G353	— with physician in continuous attendance	21.25	
G252	— interpretation only	6.70	
	Gastric lavage		
+ G355	(a) diagnostic	6.00	
G356	(b) therapeutic — with or without ice water lavage	21.25	
+ G357	Gastric secretion studies (Augmented Histamine or Histalog, or Pentagastrin) — procedure and supervision	11.70	
G352	Biliary tract provocative test with cholecystokinin	6.00	
	Anal-rectal manometry		
G354	— with physician in continuous attendance	28.30	
G253	— interpretation only	5.70	
GYNAECOLOGY			
G367	Artificial insemination	16.30	
G363	Cervical mucus penetration test	10.60	
G361	Endometrial flushing	8.50	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code		Procedural	
		Fee	Anaes.
		\$	
GYNAECOLOGY — Cont'd			
+ G364	Huhner's test (includes sample taking, examination and interpretation)	8.50	
G366	Hydrotubation — e.g. steroids	21.25	
G368	Insufflation — Rubin's test (included in tubal plastic surgery)	21.25	4
G374	Insufflation and endometrial biopsy (included in tubal plastic surgery)	21.25	4
G378	Insertion of intra-uterine contraceptive device	14.20	
Note:	For removal of I.U.D. see page 207.		
+ G365	Papanicolaou smear	3.20	
Note:	(no charge if done as part of a consultation, limited consultation, repeat consultation, general or specific assessment (or re-assessment), annual health examination or routine post-natal visit.)		
U.V.C.	Vaginal insufflation		visit fees
INJECTIONS OR INFUSIONS			
+ G369	B.C.G. inoculation, following tuberculin tests	3.20	
Note:	Multiple B.C.G. inoculations used for treatment of carcinoma are to be considered experimental and no claims should be made for this service.		
+ G370	Bursa, joint, ganglion or tendon sheath, including preliminary aspiration	12.75	
G371	(each additional site or area \$6.40, maximum \$31.95 per visit)		
Note:	G370, G371 — not allowed in addition to surgical benefits when performed at time of surgery.		
Chemonucleolysis			
Lateral discography			
G389	— lumbo sacral disc — as first disc	74.40	4
G390	— any other disc — as first disc	39.00	4
G386	— second and subsequent discs	19.50	
Injection for chemonucleolysis			
G392	— initial injection	11.00	
G393	— any subsequent injection at other levels, each	5.70	
G396	Injections of extensive keloids	15.60	
G397	— under general anaesthesia	28.30	4
Intradermal including interpretation, intramuscular or subcutaneous — with visit,			
G372	— each injection	1.40	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code		Procedural	Anaes.
		Fee	
		\$	
	INJECTIONS OR INFUSIONS — Cont'd		
	Intradermal including interpretation, intramuscular or subcutaneous — sole reason,		
G373	— first injection — apply basic charge only i.e.	3.20	
Note:	Use for tuberculin or Schick test		
G372	— each additional injection	1.40	
	Intralesional infiltration		
+ G375	— one or two lesions	5.70	
+ G377	— 3 or more lesions	8.30	
G383	— extensive (see Preamble, part B paragraph 22)	1.C.	
G384	Infiltration of tissues for trigger point	5.70	
G385	— more than one site, add	2.80	
G462	Administration of oral polio vaccine		
	— if only service rendered	1.10	
	Intravenous		
+ G376	Infant	6.40	
+ G379	Child or adult	3.90	
Notes:	(1) Use these codes for cryoprecipitate infusion.		
	(2) G376, G379 may not be claimed with G279.		
	(3) Except for chemotherapy (G381, G281), injections into established I.V. apparatus may not be claimed.		
+ G380	Cut down (including cannulation as necessary)	17.00	
	Chemotherapy (marrow suppressant) administered by intravenous infusion for treatment of malignant or auto-immune disease (maximum per visit \$15.90)		
+ G381	— single injection	8.10	
G281	— each additional injection	3.90	
G382	Supervision of chemotherapy (marrow suppressant) for malignant or auto-immune disease by telephone — monthly	7.10	
	Varicose veins (maximum per visit \$12.80)		
+ G387	— single injection	6.40	
G388	— multiple (unilateral or bilateral) each additional	3.20	
	Management of parenteral alimentation — physician in charge — up to twelve weeks		
G510	per visit	11.00	
	from thirteenth to twenty-sixth week (not to exceed \$33.00 per week)		
G511	per visit	11.00	
	from twenty-sixth week onwards (not to exceed \$66.00 per month)		
G512	per visit	11.00	
Note:	G510 — G512 may not be claimed more than once per day and the listed benefit includes the hospital visit necessary to manage the parenteral alimentation (i.e., during the same visit, a hospital visit may not be claimed in addition).		

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	NEPHROLOGY	Procedural	
		Fee	Anaes.
		\$	
G411	Nephrological management of donor procurement — (uni or bilateral) — includes management of the neurologically "dead" donor on life support systems, assessment of renal functions pre-nephrectomy, pre-nephrectomy immunotherapy, assessment as to potential recipients to be called in, etc.	120.50	
G347	Renal perfusion with hypothermia for organ transplantation	60.20	
G348	Renal preservation with continuous machine perfusion	60.20	
G412	Nephrological component of transplantation, including complete patient care for first 48 hours following transplantation	184.20	

NERVE BLOCKS

Note: Time units are not applicable to nerve blocks. If one physician gives the anaesthetic and another does the nerve block, claim the anaesthetic under G260, page 88

Not to be charged when used as local anaesthesia for surgical procedures.

G213	Auditory ganglion	34.00	
G214	Brachial plexus	34.00	
G215	Coeliac ganglion	52.40	
G239	Differential intrathecal spinal block	79.40	
G216	Epidural spinal block	46.80	
G245	Epidural or intrathecal injection of sclerosing solution	102.70	
G243	Femoral nerve — unilateral	34.00	
G244	— bilateral	51.00	

Introduction of epidural catheter for relief of pain:

G246	— Institution		5
G247	— Maintenance (one unit for each ½ hour of maintenance up to a maximum of 6 units per day.)		

Notes: — For obstetrical continuous conduction anaesthesia, see P014, P015 on page 109.

— Also see Preamble, part B, paragraph 33(n).

G218	Ilioinguinal and iliohypogastric nerves	34.00	
G219	Infraorbital	21.25	
G220	Intercostal nerve root	21.25	
G221	— for each additional one, add	10.60	
G222	Intrathecal spinal	46.80	
G225	Mental branch of mandibular nerve	21.25	
G250	Maxillary or mandibular division of trigeminal nerve	46.80	
G241	Obturator nerve — unilateral	34.00	
G242	— bilateral	51.00	
G227	Other cranial nerve block	52.40	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

		Procedural Fee	Anaes.
Code	NERVE BLOCKS – Cont'd	\$	
G228	Paravertebral nerve block of cervical thoracic or lumbar or sacral or coccygeal nerves	34.00	
G123	— for each additional one, add (to a maximum total fee of \$102.00)	17.00	
G229	Pudendal — unilateral	34.00	
G240	— bilateral	51.00	
G422	Retrobulbar injection (not to be charged when used as a local anaesthesia)	21.25	
G230	Sciatic nerve	34.00	
G226	— bilateral	51.00	
	Somatic or peripheral nerves not specifically listed		
G231	— one nerve or site	21.25	
G223	— additional nerve(s) or site(s), add	10.60	
G232	Spleno-palatine ganglion	34.00	
G233	Splanchnic	34.00	
G234	Stellate ganglion	34.00	
G256	Superior laryngeal nerve	21.25	
G235	Supraorbital	21.25	
G236	Sympathetic block(s) (lumbar or thoracic)	34.00	
G237	— bilateral	51.00	
G238	Transverse scapular nerve	34.00	
G217	Trigeminal ganglion	52.40	
E958	When alcohol or other sclerosing solutions are used, add 50% to the appropriate nerve block benefit as listed above with the exception of codes G245 and G246.		

NEUROLOGY

G273	Epidural injection of adrenal steroid or autologous blood	46.05
G274	— post laminectomy into operative site	56.70
Z804	Lumbar puncture	25.50
Z805	— with instillation of medication	34.00
G410	Amytal test (Wada) — bilateral — supervision and coordination of tests	42.50
G413	Electrocorticogram — supervision and interpretation	106.30
G419	Tensilon test	12.40
G551	Katzman test (subarachnoid infusion test) including lumbar punctures	106.30
Electroencephalography:		
+ G414	Technical component	12.40
G415	Professional component	14.50

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code		Procedural	
		Fee	Anaes.
	NEUROLOGY - Cont'd	\$	
G416	— with activating or sleep inducing drugs or sleep deprivation, add	9.90	
G417	— inserting subtemporal needle electrodes, add	9.90	
G544	Polygraphic recording of three parameters in addition to EEG (such as respiration, eye movement, EKG, muscle movements, etc.), add per item (to a maximum of \$17.10)	5.70	
G545	Videotape recording of clinical signs in association with spontaneous EEG, add per ¼ hr. (maximum of 1 hour)	9.20	
G546	Radiotelemetry or portable recordings to monitor spontaneous EEG from a freely moving patient, add	19.10	
G547	Simple average evoked potential studies with one sensory modality of stimulation	14.90	
G548	Complex evoked potential studies involving several sensory modalities, multiple threshold determinations, of more than four simultaneous channels of recording, not completely under supervision	39.00	
G549	Complex evoked potential studies performed completely under direct professional supervision	77.90	
G550	Overnight sleep recording — complete interpretation with sleep staging	56.70	
Note:	G550 — if not overnight sleep recording, see code G416.		
G418	Attendance and supervision of E.E.G. during major surgery	99.20	

OPHTHALMOLOGY

G424	Contact lens(es) fitting (with follow-up for 3 months)	116.90	
G423	One eye only, when the other eye has been previously fitted by the same physician	60.20	
Note:	G424, G423 — Contact Lens fitting is not a benefit except under certain specific conditions. See Preamble, Appendix A.		
G463	Hydrophilic "Bandage" lens fitting	60.20	
G438	Colour vision detailed assessment (not to be charged for screening tests such as Ishihara, HRR and University etc.)	16.30	
G437	Dark adaptation curve (Goldmann adaptometer or equivalent) ..	23.00	
G453	Electro-oculogram (bilateral) — interpretation benefit	13.10	
+ G439	Electro-retinography (bilateral) with report	31.90	
+ G425	Fluorescein angiography	31.90	
+ G444	Fluorescein angioscopy	9.20	
Note:	G425, G444 — for bilateral procedures, add 50% of the listed benefit.		
G426	Glaucoma provocative tests, including water drinking tests	19.10	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code		Procedural	
		Fee	Anaes.
		\$	
	OPHTHALMOLOGY — Cont'd		
G428	Hess screen examination	6.40	
G427	Ophthalmodynamometry (bilateral)	6.40	
	Radioactive phosphorus examination		
G429	— anterior approach	28.25	
G430	— posterior approach	60.20	
G421	Subconjunctival or sub-Tenons capsule injection	10.60	
Note:	G429, G430, G421 — for bilateral procedures, add 50% of the listed benefit.		
+ G435	Tonometry (bilateral)	3.40	
Note:	Not to be claimed for if done in conjunction with an ophthalmological consultation, specific assessment or reassessment.		
G433	Tonography (bilateral), to include tonometry with or without water	13.10	
G436	Visual fields — Kinetic (central and peripheral) (with permanent record)	6.40	
G432	Visual fields — Static perimetry	19.10	
G464	Visual evoked response	16.30	
	OTOLARYNGOLOGY		
+ G420	Ear syringing or curetting (may not be claimed with Z907) — uni or bilateral	3.20	
	Audiometric Tests		
	Pure tone air with or without bone conduction		
G440	— technical component	6.00	
G525	— professional component	3.90	
	— with speech tests		
G441	— technical component	8.10	
G526	— professional component	5.70	
G442	Impedance audiometry		
	— technical component	5.70	
+ G529	— professional component	3.70	
	Advanced testing (may include recruitment, sisi, tone decay, malingering, Bekesy test)		
	— per test		
G443	— technical component (maximum) \$14.25	5.70	
G530	— professional component (maximum) \$9.25	3.70	
	Hearing aid evaluation, including pure tone air and bone conduction and speech tests		
G447	— technical component	21.25	
+ G531	— professional component	7.10	
G445	Hearing aid re-evaluation — technical component	9.60	
+ G446	— professional component	3.50	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code		Procedural	
		Fee	Anaes.
	OTOLARYNGOLOGY — Cont'd	\$	
G527	Fitting of tinnitus masker — technical component	21.25	
+ G528	— professional component	7.10	
G811	Cortical evoked audiometry — technical component	14.20	
G812	— professional component	3.50	
G813	Brainstem evoked audiometry — technical component	21.25	
G814	— professional component	17.70	
G815	Electrocochleography — technical component	21.25	
G816	— professional component	56.70	
	(one or both ears) — to include myringotomy if performed		
	Vestibular Function Tests		
+ G449	Minimal caloric — professional component only	4.60	
	Fitzgerald-Hallpike method		
G450	— technical component	8.70	
+ G532	— professional component	5.70	
	Electronystagmography including caloric and positional testing		
G451	— technical component	17.40	
+ G533	— professional component	17.40	
+ G452	Electrogustometry — professional component only	9.00	
G454	Stroboscopy — professional component only	11.30	

PHYSICAL MEDICINE

Electromyography and nerve conduction studies

Schedule A:

Complete Procedure, e.g. conduction studies on two or more nerves and E.M.G. of multiple muscles and/or detailed study of neuromuscular transmission

G456	— professional component	62.35
G455	— technical component	8.85

Schedule B:

Limited Procedure e.g. conduction studies on a single nerve plus limited needle electrode, examination in one area; conduction studies on two nerves without E.M.G.

G457	— professional component	44.60
G466	— technical component	7.40

Schedule C:

Short Procedure, nerve conduction study of a single nerve or repeat E.M.G. of one or two muscles without nerve conduction

G458	— professional component	26.90
G468	— technical component	4.60

Note: For transcutaneous nerve stimulation, see "electrotherapy" under code G467.

Strength duration and chronaxie

+ G460	— major	5.70
+ G461	— minor	3.20

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code		Procedural	
		Fer	Anaes.
		\$	
	PHYSICAL MEDICINE - Cont'd		
	Therapeutic Procedures:		
+ G465	Manipulation — major joint(s) or spine — one or more joints		9.00
	(under general anaesthesia, see Surgical Procedures)		
+ G467	Not exceeding one hour as listed below		5.30
Note(s)	(1) Not allowed to hospital inpatient, outpatient or approved physiotherapy facility		
	(2) May be claimed by a physician for physiotherapy procedures performed by an appropriately trained paramedical under that physician's direct supervision (see Preamble, Part B, paragraph 19).		
	(3) Only one G467 may be charged per patient visit		
	Intermittent positive pressure breathing treatments (office).		
	Heat — diathermy, heat cabinets, heat cradles or bakers, radiant heat, whirlpool baths, paraffin baths, microtherm, etc.		
	Light — ultraviolet — general, local, orificial, etc.		
	Electrotherapy — Galvanic, Faradic, and sinusoidal currents, iontophoresis, transcutaneous nerve stimulation for relief of pain, etc. (Electrosleep therapy or Sedac therapy are not benefits of O.H.I.P.)		
	Ultra sound		
	Hydrotherapy — contrast baths — hotpacks; local, (arm and leg, whirlpool baths); general (Hubbard) for body immersion or Body Tanks; therapeutic pool, under water exercises, cryotherapy.		
	Mechano Therapy — massage, mechanical device-traction, pulleys and weights, treadles, stationary bicycles, shoulder wheels.		
	Therapeutic Exercise (physiotherapy)		
	P.U.V.A.		
	Location and injection of peripheral motor nerves for reduction of spasticity including electrodiagnosis of motor point:		
G485	Major nerve and/or branches	28.30	
G486	Additional major nerve and/or branches	17.70	
	Repeat procedure within one month		
G487	— major nerve	17.70	
G488	— additional major nerve	11.70	
N.C.	Acupuncture: i.e., including insertion of needle(s) into specifically selected point(s) combined with manual, electrical or thermal stimulation of the needle(s) for the management of pain, performed by a physician		N.A.B.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	PSYCHIATRY	Procedural	
		Fee	Anaes.
		\$	
G471	Electroconvulsive therapy (E.C.T.) cerebral-single or multiple . . .	17.70	2
Notes:	— Charges for hospital visits, home or office fees do not apply on a day when E.C.T. or individual psychotherapy is charged, i.e. by same physician, same diagnosis.		
	— Electroslleep therapy or Sedac therapy are not benefits of O.H.I.P.		
TELERADIO THERAPY			
+ G472	Minor teleradiotherapy — X-Ray, 150 K.V.P. or less — charge per treatment visit	6.55	
Note:	For the first minor teleradiotherapy procedure rendered to a patient, the physician may claim the appropriate consultation or assessment in addition to the procedure(s). On subsequent visits, only minor teleradiotherapy plus \$3.20 should be claimed unless additional procedures have been performed or unless there has been a complication or change to a totally unrelated diagnosis. In the first exception, minor teleradiotherapy plus the benefit(s) for additional procedures may be claimed. In the second exception, the appropriate assessment and minor teleradiotherapy may be claimed.		
THERMOGRAPHY (infra-red mammography) — per area (e.g. both breasts, head, both knees, both calves, etc.) No additional claim may be made for repeat thermography after injection.			
G491	Technical component	11.70	
G492	Professional component	5.80	
UROLOGY			
G484	Cystometrogram with selective sacral nerve block studies	35.40	
+ G475	Cystometrogram and/or voiding pressure studies and/or flow rate with or without postural studies and/or urethral pressure profile including intepretation with or without use of EMG including interpretation	12.75	
+ G474	— urethral pressure profile alone including interpretation	5.50	
G477	— interpretation of comprehensive urodynamic studies (when the procedure is done by paramedical personnel)	3.40	
+ G476	Prostatic massage	3.40	

OBSTETRICS

1. Obstetrical care is divided into its components. A prenatal general assessment may be claimed and shall comprise a full history, an inquiry into, and an examination of all parts or systems (and may include a detailed examination of one or more parts or systems), an appropriate record, and advice to the patient. Subsequent prenatal visits shall comprise the necessary history and inquiry, examination, appropriate record, pregnancy related counselling and advice to the patient. Normal (uncomplicated) prenatal care includes a prenatal general assessment visit, then monthly visits to 32 weeks, followed by visits every 2nd week to 36 weeks, then weekly visits until delivery. However, complicated pregnancies may require additional visits. Labour — delivery and postpartum care are listed separately.

2. If an uncomplicated obstetrical patient is transferred from one physician to another physician for obstetrical care, the appropriate assessment fee may be charged by the second physician, followed by prenatal visit fees. If the obstetrical patient is referred to a consultant for obstetrical care because of the complexity, obscurity or seriousness of the case, the consultant may claim for a consultation in addition to the prenatal visit benefits.

3. Illnesses resulting from or associated with pregnancy or false labour requiring added home or hospital care should be claimed on a per visit basis.

4. When a pregnant patient visits her physician for a condition unrelated to her pregnancy and apart from her routine scheduled prenatal visits, the physician may charge the appropriate visit benefit.

5. The listings under heading Referred Services may be claimed by the consultant physician in addition to the appropriate consultation or visit benefit. They may not be claimed by physicians providing obstetrical care to their own patients.

6. If a consultant is requested by another physician to perform a surgical induction of labour, or emergency removal of a Shirodkar suture (except at delivery) assuming someone else has inserted the suture, the consultant should claim a consultation benefit for this (these) service(s).

7. Medical induction or stimulation of labour may be claimed once per pregnancy by any one physician and only when carried out for a recognized obstetrical complication(s) and does not qualify for detention benefits.

8. The listings for "Attendance at labour and attendance at delivery" and for "Attendance at delivery" may not be claimed by any physician when a patient is transferred to a second physician for normal obstetrical care.

9. Ordinary immediate care of the newborn is included in the labour-delivery benefit and, when the service is rendered by the anaesthetist, it is included in the anaesthetic benefit. Active resuscitation of the newborn provided by any physician may be claimed under codes G521, G522 (Life Threatening Emergency Situation).

10. When a physician provides newborn care and also performs a circumcision on the same newborn or infant, both services may be claimed.

11. When an obstetrician routinely transfers all newborns to the care of another physician, the latter should not claim consultation benefits for these "transferrals". If the baby is well, the physician may claim the newborn care in hospital benefit of \$39.00 plus \$39.00 for code H267 (page 51), attendance at maternal delivery (if this service is given). If the baby is sick, the physician may claim for a general assessment and for attendance at maternal delivery (if

OBSTETRICS

this service is given) plus daily visits for as long as his/her services are required. If an obstetrician normally cares for newborns himself or transfers the care of newborns to a general or family physician but refers a newborn to a paediatrician because of the complexity, obscurity or seriousness of the case, the latter may claim for his service according to the following guidelines:

- (a) If attendance at maternal delivery is rendered, code H267 may be claimed and, if a general assessment of the baby is carried out, code C263 may be claimed as well. However a post-natal consultation on the baby (C265) may not be claimed in addition to H267.
- (b) If a paediatrician has not attended the delivery, a post-natal consultation may be claimed (if this service is rendered) even though a pre-natal consultation may already have been claimed.

12. When a physician provides prenatal visits, attends labour, assists or administers the anaesthetic at Caesarian Section and visits the patient post-operatively, he is entitled to claim for prenatal visits, attendance at delivery, assistant's or anaesthetist's benefits for Caesarian Section, and postoperative supportive care while the patient is in hospital.

13. Physicians may claim for assisted breech delivery (P020) when the service includes spontaneous delivery to the umbilicus, with extraction of the shoulders, arms and after coming head.

14. The Preamble applicable to Surgical Procedures also applies to obstetricians, where appropriate.

15. The premiums applicable to Obstetrics are as follows: When Caesarian sections or the surgical management of ectopic pregnancies commence after 5:00 p.m. and before midnight or on Saturday, Sundays and Holidays, increase the procedural fee(s) by 20% (E409). For all other obstetrical procedures e.g. deliveries occurring on Saturdays, Sundays and Holidays, increase the fee for delivery and other obstetrical procedures done in continuity with the delivery by 20% (E409). When time of delivery occurs after midnight and before 7:00 a.m. any night during the week, increase the fee for delivery and other obstetrical procedures done in continuity with the delivery by 50% (E410). These premiums are not chargeable in addition to the obstetrical procedural fee(s) if labour is induced by medical and/or surgical means by the same physician. However, a forewater A.R.M. or oxytocin augmentation of labour carried out on a patient in desultory labour does not constitute induction.

Code	OBSTETRICAL CARE	Asst.	Obst'n	Anaes.
		\$		
	Prenatal Care:			
P003	— General assessment (initial prenatal visit)		31.90	
P004	— Minor assessment (subsequent prenatal visits)		11.00	
P005	— Total prenatal care in office (applicable only to prenatal care provided for deliveries occurring prior to January 1, 1963)		152.30	

OBSTETRICS

Code	OBSTETRICAL CARE - Cont'd	Asst.	Obst'n	Anaes.
	Labour-Delivery:		\$	
P006	— Vaginal		148.80	
P020	— Operative delivery (i.e. mid-cavity rotation or assisted breech extraction)		163.00	5
P018	— Caesarean section	6	163.00	6
P041	— Caesarean section including tubal interruption ..	6	184.20	6
P042	— Caesarean section including hysterectomy	8	361.00	8
Note:	Attempted vaginal delivery, including episiotomy and repair by same physician not allowed in addition to benefits for Caesarian Section.			
E500	Multiple births, any method of delivery — each child extra		28.30	
Note:	(If one child is born vaginally and the other(s) by Caesarean section, charge P018, P041 or P042 plus one at 85% of P006 or P020, then E500)			
P038	Attendance at labour only (when patient is transferred to another centre for delivery)		70.90	
P009	Attendance at labour with physician in attendance at delivery		141.70	
P010	Attendance at delivery (attending physician or consultant(s)		70.90	
P028	Repair of third degree laceration		63.80	4
P007	Post natal care in hospital and/or home		35.90	
P008	Post natal care in office		visit fees	
	Referred services (I.O.P.) (when only service(s) rendered)			
P036	Repair of vaginal laceration		42.50	4
P039	Repair of cervical laceration		42.50	4
P029	Removal of retained placenta		42.50	4
Z774	Postpartum haemorrhage — exploration of vagina and cervix, uterine curettage		35.40	5
G224	Pudendal block (bilateral) see para. 33(n) on page 18) . .		7.10	
P013	Obstetrical anaesthesia			5
	Continuous conduction anaesthesia (see Preamble, Part B, paragraph 31(n), 31(q).			
P014	(a) introduction of catheter for analgesia including first dose			5
P015	(b) maintenance and/or supervision (one unit for each ½ hour up to a maximum of 6 units)			
E100C	(a) attendance during delivery — per ¼ hour, claim time units			
	High risk pregnancies			
Z775	Insertion of intrauterine catheter (transabdominally or transcervically)		17.00	

OBSTETRICS

Code	OBSTETRICAL CARE – Cont'd	Asst.	Obst'n	Anaes.
		\$		
Z776	Fetal blood sampling		17.00	
Z773	Fetoscopy (may include fetal blood sample, cell harvest or amniocentesis) (I.O.P.)		81.50	
Z777	N.S.T. (interpretation)		1.50	
Z739	Oxytocin challenge test (I.O.P.)		31.90	
P037	Double set up to rule out placenta praevia if patient does not proceed to Caesarean section		31.90	
P022	Oxytocin infusion for induction of labour (see paragraphs 7 and 15)		46.05	
P023	Oxytocin infusion for stimulation of desultory labour—see paragraphs 7 and 15		46.05	
Z778	Amniocentesis (I.O.P.) to include foam stability test (shake test) when indicated		15.90	
Z779	Genetic amniocentesis prior to 16 weeks of gestation (I.O.P.)		42.50	
P031	Suture incompetent cervix during pregnancy (I.O.P.) (Shirodkar procedure)	3	106.30	4
U.V.C.	Elective removal of Shirodkar suture		visit fee	
P033	Postpartum tubal interruption	6	106.30	6
P034	Uterine inversion, manual replacements		85.00	4
	(Listings for ectopic pregnancy, hysterotomy and abortion are now listed under Female Genital)			

SURGICAL PROCEDURES

Preamble:

FOR DEFINITION OF THE ROLE OF THE REFERRING PHYSICIAN, SEE REFERRING PHYSICIAN SERVICES ON PAGE 12.

FOR DEFINITION OF THE ROLES OF THE ANAESTHETIST, SEE ANAESTHETIST SERVICES ON PAGE 13.

- (1) The surgical benefit (except for fractures or dislocations requiring no reduction and other procedures either marked "I.O.P." or including complete care) includes hospital visits rendered by the surgeon two days prior to surgery, the operative procedure, the post-operative care usually associated with the procedure(s) rendered by the surgeon while the patient is in hospital, and one office visit for follow-up examination, if necessary. If the surgeon is required to provide listed services not usually associated with the procedure(s), he may claim for these. If special visits to hospital are required and rendered, the surgeon may claim the appropriate special visit premium even if the basic hospital visits are not chargeable.

The surgical benefit as noted above does not include the major pre-operative visit (e.g. consultation, general assessment, etc.) at which the decision to operate is made, regardless of the time interval between the major pre-operative visit and the surgery. The hospital or day-surgery admission assessment (consultation, repeat consultation, general assessment or re-assessment, specific assessment or re-assessment) may not be claimed by the surgeon unless it happens also to be the major pre-operative visit as defined above. Visits rendered prior to admission (excluding admission assessments) and hospital visits (minor assessments) rendered prior to two days before the surgery may be claimed in addition to the surgical benefit. For patients remaining in hospital because of complications, visit benefits may be claimed in addition to the surgical benefit after the second post-operative week. The starting point for calculating the appropriate number of hospital visits allowed in accordance with the Schedule after the second post-operative week is the date of admission if the operating surgeon has admitted the patient or the date of referral if the patient has been referred to the operating surgeon while in hospital.

The listed surgical benefit includes the generally accepted surgical components of the procedure. The listed benefit of a procedure normally also includes any necessary repair of iatrogenic damage occurring during the course of the surgery.

- (2) When a physician makes a special trip to perform a non-elective surgical procedure during the daytime (Monday to Friday), he may claim the appropriate special visit, a consultation if the case is referred (except for fractures or dislocations requiring no reduction) or the appropriate assessment if the case is not referred plus the procedural benefit(s). When the special visit is to deal with fractures or dislocations requiring no reduction, a minor assessment is the appropriate benefit to be added to the special visit and fracture or dislocation benefits. If the non-elective procedure is carried out at night (after 5:00 p.m. and before 7:00 a.m.), or Saturdays, Sundays and Holidays, the physician may claim a special visit applicable to the consultation or assessment and the surgical premium E409 or E410 (see Preamble, Part B, paragraph 20).
- (3) When more than one operative procedure (non-I.O.P.) is performed by the same surgeon at the same time and/or under the same anaesthetic or during the same hospitalization for the same condition, the benefit shall be the full benefit for the major procedure plus 85% of the listed benefit(s) for additional procedures, unless otherwise indicated in the Schedule and except where such combined operations are independently specified as items in

SURGICAL PROCEDURES

this Schedule. This paragraph applies to staged procedures and to each side of bilateral procedures, but does not apply in the case where a normal appendix or simple ovarian or para-ovarian cyst is removed incidentally during an operation, for which no claim should be made (see also OHIP Bulletin #4122, July 3, 1979).

- (4) When a subsequent operation(s) becomes necessary for the same condition because of a complication, the full benefit will apply for each procedure.
- (5) When a subsequent non-elective operation(s) is performed for a new condition, the full benefit will apply for each procedure.
When a subsequent elective procedure is done for a different condition during the same hospitalization, the benefit for the lesser procedure shall be reduced by 15% unless performed by another surgeon in which case the full benefit will apply.
- (6) When different operative procedures are done by two different surgeons under the same anaesthesia for different conditions, the benefit will be 100% of the listed benefit for each condition. Under these circumstances, the basic assistants' units should not be claimed by either operating surgeon; however time units may be claimed when appropriate.
- (7) As a general rule, when elective bilateral procedures are performed by two surgeons at the same time, one surgeon should claim for the surgical procedures and the other surgeon should claim the assistant's benefit.
- (8) Where two surgeons are working together in surgery in which neither a team benefit nor other method of claiming is set out in the schedule, the surgeon should identify himself as the operating surgeon and claim accordingly; the surgeon who is assisting him should identify himself as such and claim the assistant's benefit. Where the second or assistant surgeon is brought into the case on a consultation basis, he may, when indicated, claim a consultation as well but should be prepared to justify it on an I.C. basis. If the nature or complexity of a procedure requires more than one operating surgeon each providing a separate service in his own specialized field, each surgeon may claim the full listed benefit for the procedure he performs. This, however, does not apply to those cases wherein an additional surgeon(s) is involved simply because he may be more skillful at carrying out a procedure which the first surgeon normally should be able to do. Neither does it apply to those cases wherein one or more additional surgeons perform components of a main procedure for which there is a listed combined tariff. For the latter two circumstances, the first portion of this paragraph pertains and the additional surgeon(s) may claim assistant's benefits only, along with consultation and visits if appropriate. If a surgeon, in addition to performing a specialized portion of the procedure, acts as an assistant during the remainder of the procedure, he may also claim time units (but not basic units) for assisting.
- (9) Unless otherwise stated, the listed procedural benefits are for unilateral procedures.
- (10) When a procedure is performed, a procedural benefit, if listed, should be claimed. Substitution of consultation and/or visit benefits for procedural benefits (except as in paragraph 11), is not in keeping with the intent of the schedule.
- (11) For fractures and dislocations requiring no reduction and for other procedures which include complete care, when the listed benefit is less than the consultation benefit and the case is referred, the physician may claim for the consultation instead of the surgical benefit. However, to avoid the consultation being counted as such under the OHIP limi-

SURGICAL PROCEDURES

tation rules on the number of consultations allowed per year, the physician should claim for the consultation under the surgical procedure nomenclature or code. Since the consultation is replacing a procedural benefit which includes the pre- and post-operative and surgical care, no additional claims beyond the consultation should be made.

- (12) If a physician performs a minor surgical procedure and during the same visit assesses and treats the patient for another completely unrelated and significant problem involving another body system, the physician may claim for the procedure as well as for the appropriate assessment.
- (13) Where a procedure is specified as "Independent Operative Procedure (I.O.P.)", the procedural benefit may be claimed in full. In addition, visit benefits, consultations etc. may be claimed when both services are actually rendered. When an I.O.P. procedure is done in conjunction with non-I.O.P. procedure(s), no claim may be made for the consultation, pre- and post-operative care related to the I.O.P. procedure. The listed I.O.P. benefit may be claimed in these circumstances along with the benefits for the non-I.O.P. procedure(s) and the related major pre-operative visit in accordance with paragraph (1) of this Preamble. When multiple or bilateral I.O.P. procedures are performed at the same time by the same physician, the listed procedural benefits may be claimed in full but the pre- and post-operative benefits should be claimed as if only one procedure had been performed.
- (14) When procedures are specifically listed under Surgical Procedures, physicians should use these listings rather than applying one of the plastic surgery benefits listed under operations on skin and subcutaneous tissue.
- (15) For excision of tumours not specifically listed in this Schedule, claims should be made on an I.C. basis (code R993). Independent consideration also will be given (under code R990) to claims for other unusual but generally accepted surgical procedures which are not listed specifically in the Schedule (excluding non-major variations of listed procedures). In submitting claims, physicians should relate the service rendered to comparable listed procedures in terms of time and difficulty (see Preamble, Part B, paragraph 22).
Independent consideration also will be given (under code R991) to out-of-Province claims for generally accepted surgical procedures which are not available in Ontario, for which a patient has been referred by an Ontario physician and for which prior approval from OHIP has been obtained. (See OHIP Bulletin #4148)
- (16) Cosmetic or Aesthetic Surgery: means a service to enhance appearance without being medically necessary such as surgery for correction of facial wrinkles, surgery for eyelid wrinkles (symmetrical and without a functional problem), rhinoplasty for appearances only, etc. These services are not benefits of OHIP. (See Preamble, Appendix A).
- (17) Reconstructive Surgery: is surgery to improve normal appearance and/or function to any area altered by disease, trauma or congenital deformity. Although surgery solely to restore appearance may be included in this definition under certain limited conditions, emotional, psychological or psychiatric grounds normally are not considered sufficient additional reason for OHIP coverage of such surgery.

Appendix D of the Preamble to this Schedule describes the conditions under which surgery for alteration of appearance, only, may be a benefit of the Plan.

Physicians should submit requests to their District OHIP office for authorization of any

SURGICAL PROCEDURES

proposed surgery which may fall outside of OHIP coverage. Among those procedures for which requests *must* be submitted before the procedure is performed are:

- (a) augmentation mammoplasty (excluding post-mastectomy breast reconstruction)
- (b) blepharoplasty
- (c) dermabrasion (excluding face and neck)
- (d) epilation of hair
- (e) face lift
- (f) hair transplant
- (g) panniculectomy, lipectomy
- (h) reduction mammoplasty
- (i) rhinoplasty or septorhinoplasty
- (j) scar revision (excluding face and neck)
- (k) sex-reassignment surgery
- (l) tattoo removal (excluding face and neck)

Requests for authorization of proposed surgery should identify the medical necessity of the surgery. Moreover, since it is the procedure for which the authorization request is being made, it must be adequately described and accurately related to the condition it is intended to alleviate.

Note that when a surgical procedure is not a benefit of the Plan, the associated anaesthetist's charges, assistant's charges and hospital costs normally also are excluded from OHIP coverage.

- (18) Procedural benefits (non I.O.P.) include the removal of sutures where both services are rendered by the same physician unless the removal of sutures is done after one office visit for follow up examination has already been provided. If sutures are removed subsequent to the first post-operative office visit, or if they are removed by a physician other than the operating surgeon, or following an I.O.P. procedure, "visit fees" apply.
- (19) Additional claims for biopsies performed when a surgeon is operating in the abdominal or thoracic cavity may be given independent consideration.
- (20) When a procedure is performed for which only "local anaesthetic" and/or "general anaesthetic" listings appear, and an anaesthetic is not required, the procedure should be claimed under the "local anaesthetic" listing. When a physician administers an anaesthetic and/or other medication prior to or during a procedure(s) and also performs a procedure(s) on the same patient, he should claim for the procedure(s) only.
- (21) If claims are being submitted in coded form, the surgeon should add the suffix A to the listed procedural code, the surgical assistant should add the suffix B to the listed procedural code and the anaesthetist should add the suffix C to the listed procedural code.

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code		Asst.	Surg.	Anaes.
		\$		
	SKIN AND SUBCUTANEOUS TISSUE			
	Incision (I.O.P.)			
	Abscess(es) or Haematoma(s)			
	local anaesthetic — subcutaneous			
Z101	— one		12.90	
Z173	— two		19.50	
Z174	— three or more		25.90	
Z104	— perianal		12.90	
Z106	— ischiorectal or pilonidal		28.30	
Z103	— palmar or plantar spaces		28.30	
	general anaesthetic — subcutaneous			
Z102	— one		28.30	4
Z172	— two or more		42.50	4
Z105	— perianal		28.30	4
Z107	— ischiorectal or pilonidal		46.05	4
Z108	— palmar or plantar spaces		46.05	4
	Comedones, acne pustules, milia			
Z119	— ten or less		2.50	
Z120	— eleven or more		8.85	
Z114	Foreign body removal — local anaesthetic		12.00	
Z115	— general anaesthetic	3	56.70	4
Z100	— complicated (see Preamble, Part B, paragraph 22)	4	I.C.	4
Z116	Biopsy(s) — any method — when sole procedure		9.20	
Z155	— extensive, complicated or requiring general anaesthetic — when sole procedure (see Preamble, part B, paragraph 22)		I.C.	I.C.
	Excision (with or without biopsy)			
	Benign Lesions — single or multiple sites, uni- or bilateral (I.O.P.).			
	Group 1 — verruca, papilloma, benign keratosis, pyogenic granuloma, spider naevus, Campbell de Morgan spots			
UVC	Paring of warts or corns without complete removal		visit fees	
	Removal by excision and suture			
Z156	— single lesion		9.20	4
Z157	— two lesions		13.80	4
Z158	— three or more lesions		22.70	4

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

		Asst.	Surg.	Anaes.
Code	SKIN AND SUBCUTANEOUS TISSUE – Cont'd		5	
	Removal by electrocoagulation and/or curetting			
Z159	— single lesion		6.70	4
Z160	— two lesions		10.30	4
Z161	— three or more lesions		17.00	4
	Group 2 — naevus			
	Removal by excision and suture			
Z162	— single lesion		9.20	4
Z163	— two lesions		13.80	4
Z164	— three or more lesions		22.70	4
Z165	— congenital (extensive) (see Preamble, Part B, paragraph 22)			I.C. I.C.
Note:	Removal of naevi for cosmetic purposes and not for functional impairment or for clinical suspicion of disease or malignancy is not a benefit of OHIP (see Preamble, Appendix D) and may be billed to the patient.			
	Group 3 — plantar verruca			
U.V.C.	Paring of warts and corns without complete removal . . .		visit fees	
	Removal by excision and suture			
Z166	— single lesion		18.40	4
Z167	— two lesions		27.60	4
Z168	— three or more lesions		46.05	4
	Removal by electrocoagulation and/or curetting			
Z169	— single lesion		12.90	4
Z170	— two lesions		19.50	4
Z171	— three or more lesions		38.30	4
	Group 4 — cyst, haemangioma, lipoma			
	Face or neck			
	local anaesthetic			
Z122	— single lesion		20.50	
Z123	— two lesions		30.50	
Z124	— three or more lesions		41.80	
	general anaesthetic			
Z145	— single lesion	3	42.50	4
Z146	— two lesions	3	60.20	4
Z147	— three or more lesions	3	85.00	4
Z148	— extensive or massive (see Preamble, Part B, paragraph 22)	3	I.C.	5

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code		Asst.	Surg.	Anaes.
			\$	
	SKIN AND SUBCUTANEOUS TISSUE - Cont'd			
	Other areas			
	local anaesthetic			
Z125	— single lesion		15.90	
Z126	— two lesions		24.40	
Z127	— three or more lesions		31.90	
	general anaesthetic			
Z149	— single lesion	3	31.90	4
Z150	— two lesions	3	42.50	4
Z151	— three or more lesions	3	60.20	4
Z152	— extensive or massive (see Preamble, Part B, paragraph 22)	3	I.C.	5
R034	Congenital dermoid cyst	3	58.50	4
R037	Giant cell tumour	3	58.50	4
	Pilonidal cyst			
R035	— simple excision or marsupialization	3	116.90	4
R036	— excision and skin shift	3	155.90	4
	Inguinal, perineal or axillary skin and sweat glands for hyperhidrosis and/or hidradenitis			
R059	— unilateral	3	166.50	5
R060	— with skin graft(s) or rotation flap(s)	3	248.00	6
	Malignant and Premalignant Lesions			
	(including biopsy of each lesion) — single or multiple sites			
	Simple excision			
	localized malignancy			
R094	— single lesion	3	35.40	4
R040	— two lesions	3	58.50	4
R041	— three or more lesions	3	116.90	4
	pre-malignant lesion (i.e. solar (actinic), senile and arsenical keratoses)			
R095	— single lesion	3	13.80	4
R042	— two lesions	3	21.60	4
R043	— three or more lesions	3	45.00	4
E544	— add 25% if lesion on face or neck.			
	Curettage and electrodesiccation or cryosurgery			
	localized malignancy			
R031	— single lesion	3	35.40	4
R032	— two lesions	3	58.50	4
R033	— three or more lesions	3	116.90	4

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OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code		Asst.	Surg.	Anaes.
		\$		
	SKIN AND SUBCUTANEOUS TISSUE – Cont'd			
	pre-malignant lesion (i.e. solar (actinic), senile and arsenical keratoses)			
R053	— single lesion	3	13.80	4
R054	— two lesions	3	21.60	4
R055	— three or more lesions	3	45.00	4
R081	Chemosurgery (Mohs technique) (see Preamble, Part B, paragraph 22)		I.C.	I.C.
Notes:	(1) For cases involving R094, R095, R040-43, apply appropriate benefit listed under Repair section instead of benefit attached to the foregoing codes if corrected by advancement, rotation, transposition, "Z" plasty, flap or graft. (2) For excision of benign lesions, if closure is by pedicle flap or graft, apply closure codes instead of excision codes. If closure is by other flaps, I.C. may be given to the use of closure codes in lieu of the excision codes.			
	Repair			
	Debridement and Dressing (I.O.P.) (not to be claimed in addition to Z176, not chargeable in addition to any surgical procedure unless complication(s) require such care in excess of the usual post-operative care)			
U.V.C.	— minor		visit fees	
Z153	— major		8.50	
Z144	— requiring general anaesthetic	4	35.40	4
R082	— extensive (see Preamble, Part B, paragraph 22) . . .	4	I.C.	5
	Suture (I.O.P.)			
	Simple and uncomplicated			
Z176	— insertion of sutures only		9.20	
U.V.C.	— removal of sutures only (See Surgical Preamble, paragraph (18)		visit fees	
Z178	— extensive, multiple, complicated, primary or secondary (including post-operative haemorrhage) or requiring general anaesthetic		I.C.	4
E542	— when sutures are inserted in private office or home, add		3.50	
Notes:	(1) The benefits for Z176, Z178 include the use of sutures, local anaesthetic, tetanus toxoid and routine observation until the sutures have been removed. (2) With the accord of the Ontario Medical Association, the following guidelines are suggested to assist in the determination of an appropriate charge to submit for independent consideration under Code Z178 for suture of skin lacerations: 1. The suturing of most simple lacerations smaller than approximately 4 cm in length should be coded as Z176 and claimed accordingly.			

SURGICAL PROCEDURES

2. The suturing of other lacerations should be claimed under code Z178 on an Independent Consideration basis according to the following guidelines:
 - (a) The stated benefits are for suturing the laceration only; the appropriate consultation or visits may be claimed in addition.
 - (b) Simple lacerations with a length of 4 cm or more, but less than approximately 8 cm\$22.70
 - (c) Lacerations in difficult area (e.g. lip, eyelid, eyebrow, corner of eye, etc.) or which are deep such that they require tying off bleeders and/or closure in layers (i.e. subcutaneous and cutaneous)\$22.70
 - (d) Lacerations involving components of both (b) and (c)\$45.35
 - (e) Lacerations requiring extensive debridement, add 50%.
 - (f) A combination of 2 or 3 lacerations falling within the foregoing guidelines would require individual assessment of each laceration. e.g.: for the suturing of a 6 cm scalp laceration requiring tying off bleeders and/or layer closure, a 3 cm cheek laceration and 1 cm laceration through the mucocutaneous border of the lip, the benefit claimed could be calculated as follows:

Scalp (d)	\$45.35
Cheek (Z176)	9.20
Lip (c)	22.70
Total (Z178)	\$77.25

 (plus the appropriate consultation and visit benefits)
 - (g) More complicated lacerations should be compared in scope and difficulty with other similar services which have definitive benefits listed in the Schedule.
3. In every case, claims for Z178 should be accompanied by sufficient description of the procedure rendered and an explanation of the charges submitted (see *Preamble, Part B, paragraph 22*).

OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code		Asst.	Surg.	Anaes.
			\$	
R525	Suture of muscle laceration			
	— simple muscle repair(s) to include repair of involved skin			
R528	— complex muscle repair (see <i>Preamble, Part B, paragraph 22</i>)	3	56.70	4
		4	I.C.	6

Flaps and Grafts

- Notes:**
- (1) The benefit will depend on the size and location of the area grafted and the type of graft.
 - (2) Additional procedures other than the skin grafting are extra, e.g. tendon grafts, inlay grafts, etc.
 - (3) Skin grafts or pedicle flaps done during a procedure should be claimed for on their own merit (unless specifically listed as being inclusive for that procedure).

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OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code		Asst.	Surg.	Anaes.
		\$		
	Skin Flaps			
	A. Advancement flaps (undermining)			
R001	with undermining of 1-2.9 cm.	3	37.20	4
R002	with undermining of 3-6.9 cm.	3	56.70	4
R003	with undermining of 7-10 cm.	3	113.40	5
R004	with undermining of more than 10 cm. e.g. thoracic abdominal flap (see Preamble, Part B, paragraph 22)	4	I.C.	6
E543	— add 50% if defect on face or neck			
	B. Rotations, Transpositions, "Z" plasty(ies) (includes undermining)			
R072	Defect less than 2 cm. average diameter	3	85.00	4
R075	Defect 2 cm. to 5 cm. average diameter	3	141.70	4
R073	Defect 5 cm. to 10 cm. average diameter	4	201.95	4
R074	Defect more than 10 cm. average diameter (see Preamble, Part B, paragraph 22)	4	I.C.	5
E545	— add 50% if defect on face or neck			
	C. Pedicle Flaps — direct			
R079	Small e.g. cross finger	4	85.00	4
R077	— each subsequent stage	4	63.80	4
R070	Intermediate e.g. cervical finger	4	187.80	5
R071	— each subsequent stage	4	141.70	5
R080	Large e.g. cross leg	4	265.70	6
R078	— each subsequent stage	4	198.40	6
	D. Pedicle Flaps — indirect			
R103	Delay of tube or pedicle		40.70	4
R101	Minor stage — per operation	3	85.00	4
R100	Major stage — per operation	4	187.80	5
	E. Myocutaneous Flaps (to include closure by any method)			
R005	Sternomastoid, pectoralis major, latissimus dorsi	4	318.90	6
R006	Tensor fascia lata, gluteus maximus, gracilis, sartorius, rectus femoris, gastrocnemius (medial and lateral), rectus abdominis	3	242.70	5
R008	Extended Rectus Abdominis	6	425.20	8
R007	Other (see Preamble, Part B, paragraph 22)	I.C.	I.C.	I.C.
	Skin Grafts (Includes taking the skin for grafting)			
	A. Split Thickness Grafts			
R084	Very minor, very small areas, e.g. trauma		60.20	4

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OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code		Asst.	Surg.	Anaes.
			\$	
R085	Minor, medium sized areas, e.g. small or average skin ulcer, breast, etc.	3	92.10	4
R086	Intermediate or large areas, e.g. trunk, arms, legs, etc. .	4	170.10	4
R087	Major or complex areas, e.g. face, neck, hands, etc. . .	4	255.10	5
R088	Extensive major, very large areas, maximum for multiple sites	4	372.00	6
	B. Full Thickness Grafts			
R092	Minor — less than 1 cm. average diameter		60.20	4
R093	Intermediate — 1 to 5 cm. average diameter	3	92.10	4
R083	Major — over 5 cm. (see Preamble, Part B, paragraph 22)	5	I.C.	5
R091	Complex — eyelid, nose, lip face	4	138.20	5
Note:	Descriptive details of procedure (eg: operative report) should be submitted with claims for code R091.			
	Free Island Flaps (multiple surgery rule not applicable)			
R064	Elevation of free island skin and subcutaneous flap and closure of defect	10	602.30	10
R065	Preparation of microvascular recipient site for free island skin subcutaneous flap		602.30	
R066	Transplantation of free island skin and subcutaneous flap with microvascular anastomosis		602.30	
R067	Elevation of innervated free island skin and subcutaneous flap and closure of defect	10	662.50	10
R068	Preparation of microvascular recipient site for innervated free island skin and subcutaneous flap		662.50	
R069	Transplantation of innervated free island skin and subcutaneous flap with microvascular anastomosis and nerve repair		662.50	
R125	Elevation of free island skin and muscle flap and closure of defect	10	602.30	10
R126	Preparation of microvascular recipient site for free island skin and muscle flap		602.30	
R127	Transplantation of free island skin and muscle flap with microvascular anastomosis		602.30	
R128	Elevation of free island muscle flap with tendon and nerve, and closure of defect	10	814.90	10
R129	Preparation of microvascular recipient site for muscle, tendon and nerve anastomosis		814.90	
R130	Transplantation of free island muscle flap with tendon, nerve and microvascular anastomosis		814.90	

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OPERATIONS ON THE INTEGUMENTARY SYSTEM

		Asst.	Surg. \$	Anaes.
Code				
R131	Elevation of free island bone flaps and closure of defect . .	10	602.30	10
R132	Preparation of microvascular recipient site for free island bone flap		602.30	
R133	Transplantation of free island bone flap with microvascular anastomosis and bone fixation		662.50	
R134	Elevation of free island skin and bone flap and closure of defect	10	722.80	10
R135	Preparation of microvascular recipient site for free island skin and bone flap		722.80	
R136	Transplantation of free island skin and bone flap with microvascular anastomosis and bone fixation		722.80	
R137	Elevation of free toe or finger and closure of defect	10	722.80	10
R138	Preparation of microvascular recipient site for free toe or finger transplant		722.80	
R139	Transplantation of free island toe or finger with microvascular anastomosis and tendon nerve and bone repair		722.80	
R025	Revision of free island flaps (see Preamble, Part B, paragraph 22)	10	I.C.	10
R106	Skin flaps and grafts — other than listed above (see Preamble, Part B, paragraph 22)	I.C.	I.C.	I.C.
Neurovascular Island Transfer				
R061	Minor e.g. finger tip	3	92.10	4
R062	Intermediate e.g. finger to thumb	4	170.10	5
R063	Major e.g. foot to heel	4	283.40	6
Skin Flaps and Grafts				
Re-implantation (see Preamble, Part B, paragraph 22)				
R057	Appendage or tissue re-vascularization involving microanastomosis with or without microneuroanastomosis	I.C.	I.C.	I.C.
R058	— revision of above	I.C.	I.C.	I.C.
Digital re-implantation — see R602-R605, page 155				
Destruction				
Epilation/Electrolysis of facial hairs (I.O.P.)				
Z121	— per quarter hour		11.30	
Note:	Claims for the above procedure require O.H.I.P. authorization (see Surgical Preamble, paragraph (17)).			
Finger or toe-nail (I.O.P.)				
Z128	Simple partial or complete — one		15.20	4
Z129	— multiple		22.70	4

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code		Asst.	Surg.	Anaes.
Z130	Radical, including destruction of nail bed		\$	
Z131	— one		38.30	4
	— multiple		53.10	4
	Chemical treatment with or without photo inactivation of minor skin lesions (I.O.P.)			
Z117	— one lesion		4.25	
Z118	— two lesions		6.40	
Z143	— three or more lesions		9.20	
	Cryotherapy, carbon dioxide snow, liquid nitrogen (including treatment via duck bill acne planing tip) (I.O.P.)			
Z137	— initial or subsequent, per treatment of lesions		6.70	
	Plastic planing, Dermabrasion			
	— face for acne			
R096	— each area		63.80	4
R104	— both cheeks		134.60	4
R097	— whole face		205.50	4
R098	— single area e.g., trauma scar		37.20	4
Notes:	(1) R096, R104, R097 — not a benefit of OHIP for areas other than the face.			
	(2) R098 — Claims for this procedure require O.H.I.P. authorization (see Surgical Preamble, paragraph (17)).			
R099	Rhinophyma, removal by shaving		166.50	4
	Webbed Fingers			
R089	— one web space	4	177.15	5
Note:	benefit includes skin flaps or grafts if necessary.			
	Webbed Toes			
R090	— one web space	4	81.50	4
	Scar Revision			
R026	Up to 2.5 cm.	3	37.20	4
R027	2.5 to 5 cm.	3	56.70	4
R028	5 to 10 cm.	3	113.40	5
R029	Over 10 cm. (see Preamble, Part B, paragraph 22)	4	I.C.	6
E541	— add 50% if revision on face or neck.			
Note:	OHIP authorization is required for all scar revision in areas other than the face or neck (see Preamble, Appendix D)			
	Plastic Surgery Procedures: (see Surgical Preamble, paragraphs (14), (17)).			
R150	Very Minor		60.20	4

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code		Asst.	Surg. \$	Anaes.
R151	Minor	3	92.10	4
R152	Intermediate	4	170.10	4
R153	Major	4	255.10	5
R154	Extensive Major	4	372.00	6
Notes:	(1) Descriptive details of procedure (eg: operative report) should be submitted with claims for codes R150-R154.			
	(2) Taking of skin by a surgeon for grafting by an Oral Surgeon claim as R150.			

OPERATIONS ON THE BREAST

Incision				
Z141	Needle biopsy — one or more (I.O.P.)		15.60	
Z139	Aspiration of cyst — one or more (I.O.P.)		15.60	
	Drainage of intramammary abscess or haematoma			
	— single or multi loculated (I.O.P.)			
Z140	— local anaesthetic		15.60	
Z740	— general anaesthetic		39.00	4
Excision				
R107	Tumour or tissue for diagnostic biopsy and/or treatment e.g. carcinoma, fibroadenoma or fibrocystic disease (single or multiple — same breast)	3	85.00	4
R111	Partial mastectomy or wedge resection for treatment of breast disease e.g. carcinoma or extensive fibrocystic disease	3	127.50	4
R115	Mastectomy — male (benign) — unilateral			
	— simple	3	109.80	4
R116	— subcutaneous with nipple preservation	4	170.10	5
R108	Mastectomy — female (with or without biopsy) —			
	simple	4	170.10	5
R117	— subcutaneous with nipple preservation	4	170.10	5
R109	Mastectomy, radical or modified radical (with or without biopsy)	5	311.80	6
Z142	Removal of breast prosthesis (I.O.P.)	3	49.60	4

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code	OPERATIONS ON THE BREAST - Cont'd	Asst.	Surg.	Anaes.
		\$		
	Breast capsulotomy (I.O.P.)			
Z133	— closed manipulation — no anaesthetic		7.80	
Z134	— general anaesthetic	3	49.60	4
Z135	— open, with or without replacement of breast prosthesis	3	124.00	4
	Repair			
	Post-mastectomy breast reconstruction			
R118	— breast skin reconstruction by flaps or grafts	4	258.60	5
R119	— breast mound creation by prosthesis and/or soft tissue	4	194.90	5
Notes:	(1) R119 should not be claimed for immediate post-mastectomy prosthesis insertion. Use R112 instead.			
	(2) For reconstruction with myocutaneous flaps, see page 120.			
R114	— secondary revision of breast mound	3	145.30	4
R120	— nipple reconstruction by grafts	3	145.30	4
R113	Nipple harvesting	3	70.90	4
R121	Reconstruction of nipple areola complex by reimplantation of harvested nipple	3	88.60	4
R110	Reduction mammoplasty (female, to include nipple transplantation or grafting) — unilateral	5	290.50	7
R112	Augmentation mammoplasty — unilateral	4	127.50	4
Note:	R118-R112 — Claims for these procedures may require O.H.I.P. authorization (see Surgical Preamble, paragraphs (16), (17) and Preamble, Appendix D.).			

SURGICAL PROCEDURES

Preamble

- (1) Corrective splints must be "corrective" to qualify for benefits. The corrective splint listings are not applicable to simple immobilization such as with a Jones bandage or a metal finger splint following soft tissue injury.
- (2) The removal of a wire or pin or other device when used for traction or external fixation in the treatment of a fracture or other orthopaedic procedure is to be included in the procedural benefit. Removal of devices used for internal fixation may be claimed in addition to the procedural benefit.
- (3) The benefit for total hip replacement also includes denervation of the hip joint and adductor or abductor tenotomy.
- (4) When closed irrigation is instituted in a bony cavity, soft tissues or joint during a surgical procedure, add \$47.80 (E550).
- (5) When a bone, fascia or dermis graft is required (except for listings in which grafting is included in the benefit and except for fusions and management of pseudarthrosis) in the course of an operative procedure (including treatment of fractures) add \$50.40 (E551) if the autogenous graft is taken through a separate incision; add \$40.60 (E552) if autogenous bone is taken through the same incision, and add \$20.30 (E553) if homogenous bone is used. (except where segmental donor allografts are used to replace respective segments (see para. 8))
- (6) If methylmethacralate is required for internal fixation in the course of an operative procedure (with the exception of insertion of prostheses and cranioplasties), add \$50.40 (E547).
- (7) When an operation is done for the sole purpose of harvesting bone, the fee shall be 85% of the fee applicable for the resection of that segment of bone from a live donor and is to be charged to the recipient and a fee of \$95.70 when the segment(s) of bone are harvested from a cadaver.
- (8) For taking of a bone graft by other than the operating surgeon from the same patient, a fee of \$127.50 (Z242) shall be applicable.
- (9) Cost of materials is not a benefit of OHIP.
- (10) When secondary closure of skin wounds is required following bone surgery, claim \$63.80 (R588).
- (11) Insertion of a wire or pin for traction (excluding fractures and dislocations) \$21.25 (Z210).

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		Asst.	Surg.	Anaes.
	Application of plaster, casts or corrective splints, (I.O.P.)		\$	
	No claim should be made for the application of plaster if applied at the time of any surgery with the exception of the application of a cast brace.			
	The treatment of fractures and/or dislocations also includes initial and subsequent application of cast(s) when total fracture or dislocation care is rendered by one physician (see also Fracture Preamble paragraphs (e), (1)).			
	When plaster is applied under other circumstances, the claim for application of plaster should be made in accordance with the Schedule listings.			
	Upper Limb			
Z201	Finger			6.40

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code	Application of plaster, casts or corrective splints, (I.O.P.) — Cont'd	Asst.	Surg.	Anaes.
		\$		
Z202	Hand		10.50	4
Z203	Arm, forearm or wrist		15.90	4
	Lower Limb			
Z199	Foot		10.50	4
Z213	Below knee, knee splints (stovepipe etc.)		15.90	4
Z211	Whole leg (mid thigh to toes)		21.00	4
Z198	Toes		6.40	4
Z205	Head and torso	3	63.80	4
Z208	Shoulder spica	3	63.80	4
Z206	Body cast or shoulder spica	3	38.30	4
Z207	Hip spica bilateral — unilateral	3	63.80	4
Z209	— bilateral	3	79.70	4
Z216	Wedging of casts in other than fracture treatment		8.40	
Z200	Application of Unna's Paste		13.50	
Z873	Application of cast brace (must include hinge brace (any form including knee hinges))		56.00	
Z204	Removal of plaster (not associated with fractures or dislocations within 60 days of initial treatment)		6.40	
	BONES			
	Incision			
	Drainage of Bone (Osteomyelitis)			
	Upper Extremity — Osteomyelitis			
	Hand or Foot			
R219	Phalanx	3	86.10	4
R220	Metacarpal or metatarsal	3	86.10	4
R221	Carpus or tarsus	3	86.10	4
	Humerus			
R222	Incision and drainage	4	127.50	4
R223	Saucerization and grafting	4	287.00	4
R225	Sequestrectomy, simple	4	191.30	4
	Radius or Ulna			
R228	Incision and drainage	3	159.40	4
R229	Saucerization and grafting	3	287.00	4
R231	Sequestrectomy, simple	3	191.30	4
	Lower Extremity			
	Tibia			
R237	Incision and drainage	3	159.40	4
R238	Saucerization and grafting	3	287.00	4
R239	Sequestrectomy, simple	3	191.30	4
	Femur			
R242	Incision and drainage	3	191.30	4
R243	Saucerization and grafting — shaft or neck	5	446.40	6
R245	Sequestrectomy, simple	3	255.10	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code	BONES - Cont'd	Asst.	Surg.	Anaes.
	Pelvis		\$	
R269	Incision and drainage	3	191.30	4
R249	Sequestrectomy, simple	4	255.10	4
R250	Saucerization and grafting	4	446.40	5
	Vertebra			
R251	Incision and drainage	4	191.30	4
R252	Saucerization and grafting — posterior	4	255.10	5
R270	— anterior	6	510.20	10
R254	Posterior sequestrectomy, simple	4	255.10	4
R234	Anterior sequestrectomy	7	414.50	10
R256	Skull and Mandible — Osteomyelitis (see Preamble, Part B, paragraph 22)	7	I.C.	8
	Transection of Bone — Osteotomy			
R235	Paraglenoid	4	203.10	4
R257	Phalanx, terminal		95.70	4
E591	Each additional		35.70	
R258	Phalanx, middle or proximal, metacarpal	3	127.50	4
E592	Each additional		25.50	
R259	Radius, ulna, os calcis, fibula	3	191.30	4
R260	Humerus	4	191.30	4
R261	Tibia with or without fibula — child	3	159.40	4
R266	— adolescent or adult	3	255.10	4
R262	Femur — shaft	4	382.60	5
R263	— neck	5	382.60	7
R215	— supracondylar	4	255.10	6
R296	Spine — posterior osteotomy(s) with fusion	9	478.30	9
R264	— cervical osteotomy including fusion and instrumentation	10	765.30	12
E549	— with rib and/or transverse release, add		94.55	
R303	— anterior osteotomy(s) with fusion via chest or abdomen	9	510.20	9
R271	— anterior osteotomy(s) with fusion via chest and abdomen	9	574.00	13
R310	Circumferential osteotomy with stabilization (see Preamble, part B, paragraph 22)	9	I.C.	9
R265	Pelvis (Innominate or iliac osteotomy) — Infant	8	255.10	8
R273	— other ages	8	382.60	8
	Lower Extremity			
R276	Phalanx middle or proximal metatarsal	3	95.70	4
E596	— each additional		25.50	
R277	Midtarsal/tarsal	3	159.40	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		Asst.	Surg.	Anaes.
		\$		
	BONES - Cont'd			
	Removal of Fixation Devices (see Preamble to the Musculoskeletal System, paragraph (3)).			
R267	Incision for removal of bone plates, screws, and other appliances used for bone fixation	3	95.70	4
R268	Minor incision only under local anaesthetic	3	36.80	4
	Excision			
R272	Bone Tumour, depending on site and extent (see Preamble, Part B, paragraph 22)	I.C.	I.C.	I.C. by
	region			
	Bone Biopsy			
	Vertebra			
Z868	— with or without x-ray control (I.O.P.)	4	95.70	4
R274	— open, posterior	4	159.40	7
R275	— open, anterior	6	205.50	8
	Other			
Z869	— punch, simple (I.O.P.)		25.50	4
Z870	— punch, x-ray control (I.O.P.)		63.80	4
Z242	— open (I.O.P.) — biopsy or taking of bone graft by other than operating surgeon	4	127.50	4
Note:	R274, Z242 — Internist or haematologist should use Z403. (page L21).			
	Excision			
	Skull			
R278	Maxilla, with exenteration of orbit and skin graft . . .	4	333.00	7
R279	Maxilla advancement	4	276.35	8
R280	Mandible	4	223.20	7
R284	Mandibular condyle	4	170.10	5
	Upper Extremity			
R283	Phalanx/metacarpal	3	127.50	4
R317	Dorsal exostosis triquetrum	3	127.50	4
R285	Carpal bone — one	3	154.10	4
R316	Proximal row carpectomy	3	223.20	5
R236	Carpal bone(s), excision and replacement	3	223.20	5
	Radius			
R286	— styloid	3	127.50	4
R287	— head	3	127.50	4
R288	— head with replacement	3	154.10	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code	BONES — Cont'd	Asst.	Surg.	Anaes.
			\$	
	Ulna			
R289	— lower end/styloid process	3	127.50	4
R281	— with replacement	3	159.40	4
R290	— olecranon	3	127.50	4
R291	— olecranon and fascial repair	3	159.40	4
	Humerus			
R292	— Head	4	203.10	5
R294	— exostosis	4	99.45	4
R295	— benign tumour — simple excision	4	193.30	4
R297	— malignant tumour with reconstruction	4	510.20	6
R298	— Acromion or outer end of clavicle	4	129.60	4
	Lower Extremity			
	Foot Bones			
R299	— proximal phalanx (with or without R309)	3	77.00	4
E587	— each additional		25.50	
R300	— tumour of phalanx, excision	3	127.50	4
R301	— sesamoids, one or both	3	99.45	4
R302	— bunion (ette) — exostectomy only			
	— unilateral	3	82.90	4
R305	— scaphoid, accessory	3	99.45	4
R306	— tarsal bar	3	143.50	4
R307	— calcaneal spur, exostosis or bony prominence ..	3	87.55	4
R282	— excision of exostosis	3	49.00	4
R308	— os calcis or talus	3	191.30	4
R309	— metatarsal head (with or without R299)	3	95.70	4
E587	— each additional		25.50	
	Tibia			
R311	— exostosis	3	127.50	4
	— tumour (see humerus)			
R210	Fibular head	3	127.50	4
	Patella			
R312	— simple	3	143.60	4
R313	— with reconstruction or fascial repair	3	231.10	4
	Femur			
R314	— exostosis	4	159.40	4
R315	— head and neck	4	318.90	6
R330	— tumour — simple	4	318.90	6
R216	— extensive	8	510.20	8
	Trunk			
N284	— first rib — complete removal	6	265.70	6
E540	— with cervical rib, add		53.10	
Z337	— rib resection for drainage (I.O.P.)	6	77.90	6

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		Asst.	Surg.	Anaes.
			\$	
	BONES — Cont'd			
R373	Spine — spinous process	4	159.40	4
R374	— lamina or transverse process	6	255.10	8
R450	— part of body or pedicle	6	382.60	8
R455	— total body (includes replacement)	9	637.70	13
	Management of Pseudarthrosis (non union of bones or joints) — applicable four months after fracture and includes bone grafts. If skeletal fixation is added or revised, add \$51.00 (E590) to the surgical benefit for the management.			
R321	Metacarpal, tarsal or phalanx	3	159.40	4
R322	Scaphoid	3	192.60	4
R323	Radius or ulna	3	191.30	4
R324	Radius and ulna (including reconstruction of congenital anomalies synostosis, etc.)	3	287.00	4
R325	Humerus	4	192.60	4
R326	Tibia — adult	4	223.20	5
R372	— congenital	4	318.90	6
R363	Lateral or medial malleolus (non-union)	3	168.10	4
R327	Fibular transfer (non vascular)	4	255.10	6
R328	Femur, neck or shaft	6	318.90	6
R364	Pelvis (non-union) (see Preamble, Part B, paragraph 22)	I.C.	I.C.	I.C.
R329	Clavicle	4	168.10	4
Z250	Electrical stimulation for non-union (I.O.P.)		140.10	4
Note:	Z250 includes application of electrodes (internal and/or external).			
	Repair, Manipulation and Reconstruction			
	Lengthening of Bone			
R331	Tibia	4	262.65	4
R332	Femur	4	329.20	4
	Shortening of Bone			
R458	Tibia	4	255.10	4
R333	Femur	4	318.90	4
R337	Metatarsal — one	4	127.50	4
R338	— more than one	4	175.10	4
	Fusion of bone — Epiphysiodesis			
R339	Tibia	4	203.10	5
R340	Femur	4	203.10	5
R341	Tibia and Femur	4	287.00	5
	Epiphyseal Stapling			
R342	Tibia — one side	4	127.50	4
R460	— both sides	4	159.40	4
R343	Femur	4	159.40	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

		Asst.	Surg.	Anaes.
Code	BONES — Cont'd		\$	
R344	Tibia and Femur	4	255.10	5
	Scoliosis, Kyphosis and Kyphoscoliosis (spinal curvatures, deformities)			
R356	Corrective localizer cast		73.50	4
R345	Definitive care, corrective cast(s) and fusion (includes R356)	8	574.00	9
	Harrington procedure (for correction and fixation of fracture dislocations of spine see pg 142.			
R347	— without fusion	8	500.80	12
R362	— with fusion	8	637.70	12
E554	— with posterior osteotomy, add		95.70	
	Anterior release including Halo pelvic or Halo femoral traction			
R358	— via chest or abdomen	9	382.60	13
R357	— via chest and abdomen	9	446.40	13
R369	Instrument re-adjustment		99.45	4
	Revision of entire instrumentation			
R336	— without fusion	8	637.70	12
R346	— with fusion	8	797.20	12
R348	Removal of apparatus — posterior	8	127.50	8
R461	— anterior	8	191.30	8
R349	Revision of failed procedure with osteotomy of spine (see Preamble, Part B, paragraph 22)	8	I.C.	12
R370	Luque procedure — without fusion	8	630.30	12
R371	— with fusion	8	797.20	12
	Anterior instrumentation of spine including discectomies and fusion			
R350	— via chest or abdomen	9	956.60	17
R359	— via chest and abdomen	9	1052.30	17
R361	Halo pelvic or Halo femoral traction prior to surgery for correction of spinal deformities (complete care)	3	191.30	4
R464	Muscle stripping of spine (as a separate procedure) prior to surgery for correction of spinal deformities	6	127.50	8
R365	Electrospinal instrumentation	8	382.60	10
R366	— with muscle stripping of spine	8	478.30	12
R367	— repair and/or replacement of electrodes	8	147.10	10
R368	— removal of electrospinal instrumentation	8	127.50	8
	Reconstruction of Mandible			
	Reconstruction of mandible with bone graft			
R334	— partial	4	308.20	10
R335	— complete	4	460.60	10

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		Asst.	Surg. \$	Anaes.
	BONES - Cont'd			
R354	Interdental wiring for temporomandibular joint disorder, including removal of wires	3	106.30	5
R375	Reconstruction for major congenital abnormalities affecting the face and skull — not otherwise listed (see Preamble, Part B, paragraph 22)	I.C.	I.C.	I.C.
	Hypertelorism correction			
R376	— intracranial approach	12	1300.30	25
R377	— subcranial approach	12	967.20	25
R378	Total maxillary advancement — Le Fort III osteotomy with bone grafts	12	1027.50	25
R379	Lower maxillary osteotomy and advancement (simple) Le Fort I osteotomy with bone grafts	10	488.90	20
R380	Lower maxillary osteotomy and advancement — dental arch in two segments	10	648.40	20
R381	Lower maxillary osteotomy and advancement (complex) — dental arch in three or more segments	10	765.30	20
R382	Dento-Alveolar osteotomy (simple) — Koe or Wassmund procedure	6	325.95	10
R383	Dento-Alveolar osteotomy (complex) — anterior or posterior movement of dental segment in two or more sections	6	432.20	10
R384	Mandible osteotomy for retrognathia or prognathism (one or more stages)	6	467.70	10
E588	— when combined with apertognathia or lateratognathia add		109.80	
	Application of dental arch bars for facial osteotomies			
Z239	— one arch bar (I.O.P.)	4	56.70	4
Z240	— two arch bars (I.O.P.)	4	109.80	4
	Genioplasty for facial reconstruction			
R386	— one step advancement	6	109.80	10
R387	— two step advancement	6	134.60	10
R388	— three step advancement	6	191.30	10
R389	Le Fort II maxillary osteotomy and advancement with bone grafts	10	765.30	20
R390	Peri-Orbital correction of Treacher-Collins Syndrome, with rib and iliac grafts	10	868.00	20
	Correction of unilateral orbital dystopia			
R391	— total repositioning one orbit — intracranial approach	12	868.00	25
R392	— subtotal repositioning one orbit — extracranial approach	10	648.40	20
R393	Complete forehead advancement	12	435.80	25

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		Asst.	Surg.	Anaes.
	BONES - Cont'd		5	
R394	Cranial vault reconstruction for oxycephaly, brachycephaly, turriccephaly	10	843.20	20
R395	Reconstruction of glenoid fossa, zygomatic arch and temporal bone (Obwegeser technique)	10	804.30	20
R396	Construction of absent condyle and ascending ramus in hemifacial microsomia	6	411.00	10
R397	Facial bone reconstruction by onlay multiple bone grafts (see Preamble, Part B, paragraph 22)	I.C.	I.C.	I.C.
R398	Transnasal canthopexy	3	223.20	6
R399	Lateral canthopexy	3	170.10	6
R385	Reconstruction of skull (see Preamble, Part B, paragraph 22)	I.C.	I.C.	I.C.
N201	Rib graft cranioplasty (defect less than 7.5 cm.)	11	566.90	15
	Reconstruction of Chest			
	Pectus excavatum or pectus carinatum (by reconstruction, not implant)			
R351	— infant	3	170.10	6
R352	— other than infant	6	315.30	11
Note:	R334-R399 — see Surgical Preamble, paragraph (17)			
R353	Scapulopexy — congenital elevation or winged scapula	6	255.10	6
	Reconstruction of Foot			
	MP fusion (great toe) — listed under Joints			
	Toe fusion alone — listed under Joints			
	Each additional toe — listed under Joints			
R309	Phalangectomy and/or excision of metatarsal head — also listed under Excision	3	95.70	4
E587	— each additional — also listed under Excision		25.50	
	Hallux valgus			
R304	— Simple (e.g. Keller, Mayo)	3	127.50	4
R355	— Extensive, may include osteotomy, tendon transfers, exostosectomy, bone grafts, etc. (e.g. Joplin, reverse Joplin, Lapidus, MacBride or Mitchell) unilateral	3	175.40	4
R360	Major forefoot reconstruction requiring multiple procedures — maximum — unilateral	3	255.10	5
Note:	Combinations of procedures on the forefoot should be claimed under the multiple surgery rules. However, the total benefit for such combinations (unilateral) may not exceed the listed benefit for R360.			
	Congenital club foot — see Arthrodesis — p. 148;			
	Manipulation — p. 150.			

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

FRACTURES AND DISLOCATIONS

Preamble

- (a) **OPEN REDUCTION** shall mean the reduction of a fracture or dislocation by an operative procedure **or the treatment of the fracture by intramedullary fixation that might not include the opening of the fracture.**
- (b) **CLOSED REDUCTION** shall mean the reduction of a fracture or dislocation by non-operative methods (to include skin traction or K wire or Steinmann's pin for balanced traction.)
- (c) **CLOSED REDUCTION and immobilization by percutaneous pinning of a fracture or dislocation shall command a closed reduction fee plus 30% (E569). Immobilization by rigid external skeletal fixation shall command a fee of 40% (E555) above closed reduction fee.**
- (d) **NO REDUCTION** shall mean the treatment of a fracture or dislocation by any method other than that designated in (a), (b), or (c) above **and includes the use of the initial external support.**
- (e) The listed benefits for fractures or dislocations requiring no reduction include the major pre-operative visit. For fractures or dislocations requiring reduction, the major pre-operative visit (e.g. consultation, general assessment, etc.) may be claimed in addition to the listed benefits for reductions.
The stated benefit is to cover full treatment by the physician claiming that benefit, including initial and subsequent application of cast(s) and necessary after care up to 2 months (includes Therapeutic Procedures under G467), except as in (g) and (h) following.
- (f) For combinations of fractures, dislocations, and/or surgical procedures (non I.O.P.), the benefit for the major fracture, dislocation or procedure shall be 100%, and the benefit for other fractures, dislocations and/or surgical procedures shall be 85% **where a procedural fee is applicable. Where no procedural benefit is applicable but where that fracture necessitates hospitalization or concurrent care, a visit fee will apply in addition to the procedural fees stated above.**
- (g) In cases where two or more reductions (closed or open) are performed on different occasions for one fracture or dislocation by one or more surgeons; the full benefit should be claimed for the final reduction and after care. Previous attempted reduction(s) should be claimed at 75% of the full listed benefit(s) for that reduction.
- (h) When a patient is transferred from an acute care hospital to a chronic or convalescent facility, additional benefits on a chronic care basis shall be allowed to other than the operating surgeon. These benefits shall be based on the chronic care schedule.
- (i) Compound fractures or dislocations, requiring extensive debridement — 50% over the benefit for reduction (**E556**).
- (j) If reconstructive procedures on soft tissues are required, such services should be claimed on their own merit.
If bone grafts are used in open reduction of a fracture, paragraph (6) of the Preamble to the musculoskeletal system applies.

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM FRACTURES AND DISLOCATIONS - Cont'd

- (k) When a patient is transferred to another surgeon for after care of a fracture or dislocation treated by no reduction or closed reduction, except for emergency splinting (see paragraph (l), below) the surgeon rendering the initial care should claim 75% of the listed benefit and the surgeon rendering the subsequent care **visit fee** except where otherwise specified. In cases involving open reduction, the percentages should be 80% **for the surgeon providing the initial care**. Paragraph (11) of the Preamble to Surgical Procedures also applies.
- (l) The benefit for emergency splinting of a fracture in the emergency department should be on the basis of the emergency room visit or the special visit to the hospital, whichever applies, plus application of cast if rendered and if consistent with other portions of this preamble.
- (m) In the case of fractures, dislocations or minor avulsion fractures not requiring reduction, **consultation** or visit benefits (use a fracture diagnosis) shall apply unless a specific benefit is listed. For fractures listed at "visit fees", the following also apply:
 - (1) When two or more fractures, *each* listed at "visit fees", are treated, only one visit benefit should be claimed for each visit, even though more than one fracture is assessed, treated, or re-assessed.
 - (2) When fractures or other procedures which are listed at "visit fees" are treated along with treatment of fractures which have definite benefits listed, visit benefits should not be claimed in addition to claims for other fracture care.
 - (3) When fractures or other procedures which are listed at "visit fees" are treated along with the performance of non-IOP surgery, visit benefits should not be claimed in addition to claims for the surgery.
 - (4) For the combinations described in items (2) and (3) above, visit benefits are appropriate for follow-up care of the fractures listed at "visit fees" only for visits which, because of these fractures, are required in addition to the usual after-care of the other fractures or other surgery.
- (n) In case of fractures or fracture dislocations with associated paraplegia, hospital visit benefits may be charged in addition to the surgical benefit after two weeks of post-operative care.
- (o) The removal of a wire or pin or other device when used for traction or external fixation in the treatment of a fracture or other orthopaedic procedure is to be included in the procedural benefit. Removal of devices used for internal fixation may be charged for in addition to the procedural benefit.

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		Asst.	Surg.	Anaes.
			\$	
	FRACTURES			
	Upper Extremity			
	Phalanx-terminal, middle and proximal			
F004	— no reduction, rigid immobilization		28.70	
F005	— closed reduction		63.80	4
E558	— each additional		15.90	
F007	— open reduction	4	95.70	4
	Intra-articular fracture — I.P. joint			
F006	— closed reduction		51.00	
F010	— open reduction	3	95.70	4
	Metacarpal			
F008	— no reduction, one or more, rigid immobilization		28.70	
F009	— closed reduction, one or more		63.80	4
F011	— open reduction	4	95.70	4
E559	— each additional		31.90	
	Bennett's Fracture — dislocation			
F012	— no reduction, rigid immobilization		28.70	
F013	— closed reduction	3	63.80	4
F015	— open reduction	4	127.50	4
	Carpus (excluding scaphoid)			
F102	— no reduction, rigid immobilization		28.70	
F016	— closed reduction, one or more		63.80	4
F017	— open reduction, one or more	4	127.50	4
	Scaphoid			
F018	— no reduction, rigid immobilization		63.80	
F019	— open reduction	4	159.40	4
F020	— partial excision	4	127.50	4
	Radius and Ulna			
F014	— no reduction, rigid immobilization		44.60	
F022	— Monteggia — closed reduction		95.70	4
F023	— open reduction of ulna plus closed reduction of radial head . . .	3	133.90	4
F024	Shafts — no reduction, rigid immobilization		44.60	
F025	— closed reduction	3	95.70	4
F026	— open reduction	4	242.30	4
	— Colles (Barton's, Smith's) —			
F027	— no reduction, rigid immobilization		44.60	
F028	— closed reduction	3	70.15	4
F030	— open reduction	4	136.60	4
	Radius or Ulna			
F031	— no reduction, rigid immobilization		44.60	
F032	— closed reduction	3	70.15	4
F033	— open reduction	4	133.10	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code	FRACTURES - Cont'd	Asst.	Surg.	Anaes.
		\$		
	Olecranon			
F034	— no reduction, rigid immobilization		44.60	4
F035	— closed reduction	3	70.15	4
F036	— open reduction	4	127.50	4
	Intra articular fracture-elbow			
F021	— open reduction	4	191.30	5
	Humerus			
	Epicondyle — medial or lateral			
F029	— no reduction		44.60	
F037	— closed reduction	3	70.15	4
F038	— open reduction	4	111.60	4
	Supra or transcondylar			
F039	— no reduction		44.60	
F040	— closed reduction	3	127.50	4
F041	— open reduction	4	223.20	4
	Shaft			
F042	— no reduction		44.60	
F043	— closed reduction	3	95.70	4
F044	— open reduction	4	191.30	4
	Tuberosity			
F047	— no reduction		44.60	
F048	— closed reduction	3	79.70	4
F049	— open reduction	4	191.30	4
	Neck with dislocation of the head			
F050	— no reduction		44.60	
F051	— closed reduction	3	121.20	4
F052	— open reduction	5	223.20	6
	Neck without dislocation of the head			
F053	— no reduction		44.60	
F054	— closed reduction		79.70	4
F055	— open reduction	5	191.30	6
	Lower Extremity			
	Phalanx			
F056	— no reduction, rigid immobilization		28.70	
E560	— each additional		6.40	
F058	— closed reduction		38.30	4
E561	— each additional		9.60	
F060	— open reduction	4	79.70	4
	Intra-articular fracture — I.P. joint			
F057	— closed reduction		51.00	
F059	— open reduction	3	95.70	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		Asst.	Surg.	Anaes.
			\$	
	FRACTURES — Cont'd			
	Metatarsus			
F061	— no reduction — one or more		28.70	
F062	— with rigid immobilization		44.60	
F063	— closed reduction — one or more	3	57.40	4
F064	— open reduction — one	4	79.70	4
F065	— two or more	4	143.50	4
	Tarsus — excluding os calcis — one or more			
F066	— no reduction, rigid immobilization		63.80	
F067	— closed reduction	3	79.70	4
F068	— open reduction	4	143.50	4
	Os calcis			
U.V.C.	— no reduction — no cast		visit fees	
F070	— rigid immobilization		63.80	
F071	— closed reduction (manipulation)		79.70	4
F072	— open reduction	4	159.40	4
	Ankle fracture or fracture-dislocation			
F074	— no reduction, rigid immobilization		44.60	
F075	— closed reduction	3	95.70	4
	— open reduction			
F076	— of one malleolus	4	143.50	4
F077	— of more than one malleolus	4	203.10	5
F090	— one malleolus and closed reduction of one or two malleoli	4	203.10	5
	Tibia — with or without Fibula			
F078	— no reduction, rigid immobilization		76.50	
F079	— closed reduction	3	127.50	4
F080	— open reduction — shaft	4	223.20	5
F081	— plateau	4	255.10	5
F104	Plafond tibial fracture — closed	3	159.40	4
F108	— open	4	239.15	6
	Fibula only			
F082	— no reduction, rigid immobilization		44.60	
F083	— closed reduction		63.80	4
F084	— open reduction	4	111.60	4
	Patella			
F085	— no reduction		44.60	
F087	— open reduction — excision and/or simple repair	4	164.60	4
F088	— excision and fascial repair	4	224.10	5

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code	FRACTURES - Cont'd	Asst.	Surg.	Anaes.
		\$		
	Femur			
	Shaft or transcndylar			
U.V.C.	— no reduction — bed rest		visit fees	
	— closed reduction — with or without anaesthetic			
F093	— infant		127.50	4
F094	— child	3	159.40	4
F095	— adolescent or adult	3	255.10	4
F096	— open reduction with internal/external fixation	6	318.90	8
	Neck or intertrochanteric			
U.V.C.	— no reduction		visit fees	
F098	— closed reduction/ traction	3	255.10	4
F099	— open reduction — pin only	6	255.10	8
F100	— pin and plate	6	350.75	8
F101	Prosthesis, head of femur	6	287.00	8
F091	Delayed/staged graft	6	255.10	8
	Spine			
	Trauma			
U.V.C.	Fracture of spinous or transverse process, facet, etc. .		visit fees	
	Fracture, dislocation, or fracture-dislocation			
Z236	— skull calipers (I.O.P.)		42.50	
Z241	— Halo traction (I.O.P.)		51.00	
Z246	— re-application of Halo traction (I.O.P.)		31.90	
E562	— with counter traction, femoral or iliac pin or vest, add		70.90	
	Without cord injury:			
F103	— closed reduction with or without anaesthetic, rigid immobilization, frame, brace, etc.		127.50	5
U.V.C.	— supervision, bed rest only		visit fees	
F105	— open reduction	5	155.90	5
F106	— with fusion and/or internal fixation	7	350.75	10
F107	— anterior discectomy and fusion and/or internal fixation	7	350.75	10
E548	— with instrumentation, add to F106, F107 or F111		63.80	
E570	— at two or more levels, add to F106, F107 or F111		51.00	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		Asst.	Surg.	Anaes.
	FRACTURES - Cont'd		5	
	With cord injury:			
U.V.C.	— no operation		visit fees	
F109	— closed reduction under anaesthesia	5	255.10	5
F111	— open reduction and fusion and/or internal fixation	7	382.60	10
E548	— with instrumentation, add to F106, F107 or F111		63.80	
E570	— at two or more levels, add to F106, F107 or F111		51.00	
Note:	For spinal cord decompression procedures, see page 216.			
	Sacrum			
U.V.C.	— complete care		visit fees	
	Coccyx			
U.V.C.	— no reduction		visit fees	
F115	— excision	4	127.50	4
	Trunk			
U.V.C.	Clavicle — no reduction		visit fees	
F110	— closed reduction with anaesthetic	3	41.45	4
F118	— open reduction	4	127.50	4
	Scapula — body, neck or glenoid			
F119	— no reduction		44.60	
F120	— closed reduction		76.50	
F121	— open reduction	4	159.40	5
	Sternum			
F122	— no reduction		44.60	
F123	— closed reduction		76.50	
F124	— open reduction — benefit will depend on extent of operations and complications (see Preamble, Part B, paragraph 22)		I.C.	
F125	— pleura closed	4		4
F126	— pleura open	9		13
	Ribs			
U.V.C.	— uncomplicated		visit fees	
F130	— complicated — requiring special treatment (see Preamble, Part B, paragraph 22)		I.C.	
F131	— pleura closed	4		4
F132	— pleura open	9		13
	Pelvis			
U.V.C.	— no reduction, bed rest and supervision		visit fees	
F134	— closed reduction, manipulation and control	3	318.90	4
F135	— open reduction	6	446.40	8

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code	FRACTURES - Cont'd	Asst.	Surg.	Anaes.
			\$	
	Head			
	Orbit			
	open reduction of rim/wall fracture			
E173	— zygomatic fracture dislocation	4	173.60	6
E174	— blow out fracture of floor	4	201.95	6
E175	— secondary repair by combined orbital approach	4	297.60	6
F143	— middle 1/3 facial	5	269.30	6
F144	— cranio-facial separation	5	336.60	8
	Nasal bones			
U.V.C.	— no reduction		visit fees	
F136	— closed reduction		60.20	4
F137	— open reduction		124.00	4
F117	— complicated with internal or external fixation ..		180.70	5
	Mandible			
U.V.C.	— no reduction — no wiring of teeth		visit fees	
F138	— closed reduction — including wiring of teeth ..		159.40	5
	— open reduction (may include wiring of teeth)			
F139	— one side	4	212.60	5
F146	— complicated (see Preamble, Part B, paragraph 22)	I.C.	I.C.	I.C.
F140	— removal of interdental wire			4
	Maxilla, Malar bone			
U.V.C.	— no reduction		visit fees	
F150	— closed reduction and dental wiring		159.40	5
F141	— open reduction — simple	4	92.10	5
F142	— with wiring and local fixation	5	244.50	6
	Skull			
	— for repair of depressed and other skull fractures, see codes N139, N140 on page 215			
	JOINTS			
	Endoscopy (I.O.P.)			
	Arthroscopy			
Z218	Large joint		63.80	4
Z219	Small joint (M.P. or I.P. joint)		41.45	4
	If followed by open surgery of joint under same anaesthetic when performed by same physician, add to surgical benefit			
E595	— small or large joint		41.45	
E563	— with biopsy, add		6.40	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		Asst.	Surg.	Anaes.
		\$		
	JOINTS — Cont'd			
	Incision			
Z220	Aspiration (I.O.P.)		12.75	
Z221	Needle biopsy (I.O.P.)		31.90	
	Arthrotomy			
R409	Finger — open		95.70	4
R410	Wrist	3	127.50	4
R445	Elbow, loose body etc.	3	111.69	4
R411	Shoulder	4	127.50	4
R416	Coraco-acromial ligament division, with or without exploration of rotator cuff, with or without acromioplasty	4	129.60	4
Note:	R416 may not be claimed with R298			
R412	Knee — exploratory and/or removal of loose body . .	3	127.50	4
R413	Knee — osteochondritis dessicans — drilling and/or internal fixation	3	175.10	4
R415	Hip — exploratory — with or without removal of loose body	5	191.30	6
R503	Ankle, loose body etc.	3	111.60	4
E539	— with osteotomy of malleolus, add		79.70	1
R504	Foot joints	3	95.70	4
R505	Metatar-al/phalangeal	3	95.70	4
	Excision			
	Capsulectomy — Synovectomy — Debridement			
R420	Ankle	3	203.10	4
R421	Elbow	3	223.20	4
R422	Shoulder	4	318.90	5
R423	Hip	5	350.75	6
R424	Knee	3	318.90	5
R417	Knee debridement without synovectomy	3	191.30	4
R501	Meniscus cysts	3	82.90	4
R418	Wrist	3	255.10	4
R425	Fingers, toes — one	3	159.40	4
R414	— two or more	3	255.10	4
	Denervation			
R426	Elbow, knee	3	159.40	4
R427	Hip	4	255.10	5
	Chondrectomy			
R490	Acromio clavicular meniscectomy	3	127.50	4
R491	Sternoclavicular meniscectomy	3	127.50	4
R492	Radio ulnar meniscectomy	3	143.50	4
R428	Temporo-mandibular meniscectomy	5	159.40	5
R429	Knee-meniscectomy (one meniscus) and/or shaving of articular surfaces	3	159.40	4
E598	— With patellar prosthesis or patelloplasty, add . . .		63.80	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		Asst.	Surg.	Anaes.
	JOINTS - Cont'd		\$	
R431	Baker's cyst	3	82.90	4
R434	— extensive		159.40	6
	Reconstruction			
Note:	Arthroplasty — all types			
	In the revision of an arthroplasty, add 35% to the new arthroplasty benefit (E564).			
R433	Temporomandibular joint — unilateral	5	223.20	5
R444	Acromio or sternoclavicular	4	127.50	4
R487	Shoulder — complete replacement	6	510.20	10
R498	— removal of shoulder prosthesis without replacement	3	255.10	8
R438	Shoulder, (unipolar)	4	318.90	6
R486	Elbow — complete replacement	6	350.75	8
R499	— removal of elbow prosthesis without replacement	3	255.10	7
R510	Interposition arthroplasty	6	287.00	7
R437	Wrist	3	255.10	5
R485	Wrist, ankle — complete replacement	6	287.20	6
R479	— removal of wrist or ankle prosthesis without replacement	3	171.60	6
	Hand, reconstruction — I.P. or M.P. joint			
	— without prosthetic replacement			
R435	— single	3	159.40	5
R436	— multiple	3	287.00	6
	— with prosthetic replacement			
R489	— single	3	199.60	5
R449	— multiple	3	510.20	6
R500	— removal of P.I.P. or M.C.P. prosthesis without replacement	3	122.60	4
R439	Hip — femoral prosthesis	6	318.90	8
R443	— removal of femoral prosthesis or cup without replacement non cemented	3	255.10	8
R440	— cup or total (including neurectomy)	8	510.20	8
R488	— removal of total hip prosthesis without replacement-cemented	3	318.90	8
E589	— bone graft to deficient acetabular floor, add ...		63.80	
E593	— extensive acetabular reconstruction including bone grafts, add		140.10	
R481	— re-attachment of greater trochanter (late)	6	213.60	8
R442	— resurfacing hip arthroplasty	8	637.70	8

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		Asst.	Surg. \$	Anaes.
	JOINTS - Cont'd			
	Knee			
R441	— complete replacement	6	446.40	8
R482	— hemi-arthroplasty (single component)	6	203.10	6
R483	— hemi-arthroplasty (double component)	6	294.20	6
R508	— meniscal suturing	3	159.40	5
R509	— patellar arthroplasty	3	159.40	5
E598	— with patellar prosthesis or patelloplasty, add ...		63.80	
R496	— removal of knee prosthesis (single component) without replacement	4	159.40	5
R497	— removal of knee prosthesis (double component) without replacement	4	207.30	5
	Foot			
	— M.T.P. joint without prosthetic replacement			
R456	single	3	154.80	5
E538	— each additional, add		25.50	
	— with prosthetic replacement			
R453	single	3	199.60	5
R454	multiple	3	294.20	6
R446	— overlapping 5th toe	3	99.45	4
R430	— repair of hammer toe — any technique (e.g. girdlestone tendon transfer; Higge procedure), unilateral (may include tenotomy or syndactyly)	3	105.10	4
E594	— each additional hammer toe		29.40	
	Intervertebral Discs			
R457	Lumbar hemilaminectomy for disc disease with or without nerve root decompression (soft disc, osteophyte)	6	255.19	8
E567	— with fusion — 1 level, add		165.80	
E568	— two or more levels, add		216.80	
E565	— with multiple levels, add per additional level		44.60	
E566	— bilateral, add		44.60	
R451	Cervical hemilaminectomy for disc disease with or without root decompression (soft disc, osteophyte) — single or multiple levels	6	382.60	10
E566	— bilateral, add		44.60	
E567	— with fusion — 1 level, add		165.80	
E568	— two or more levels, add		216.80	
R493	— fusion, separate surgeon — one level		210.10	
R494	— two or more levels		245.10	
R452	Anterior lumbar discotomy, single	6	318.90	10
S312	— exposure (laparotomy) by different surgeon	6	155.90	6
R447	Anterior cervical discotomy	8	318.90	10

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		Asst.	Surg.	Anaes.
	JOINTS - Cont'd		\$	
R480	Anterior thoracic discotomy	9	318.90	13
M137	— exposure (thoracotomy) by different surgeon	9	240.90	13
E567	— with fusion — 1 level, add		165.80	
E568	— two or more levels, add		216.80	
E565	— with multiple levels, add per additional level		44.60	
E566	— bilateral, add		44.60	
Note:	For spinal cord decompressive procedures, see page 219.			
	Arthrodesis			
R419	C-1, C-2 fusion	8	331.60	9
	Spinal column (uni- or bilateral)			
R459	— one space	7	262.65	8
E573	— each additional space (to a maximum of 2 additional), each		63.80	
R462	Anterior approach — thoracic	8		13
R463	— lumbar	8		10
E574	Re-fusion of spine, add		133.90	
R465	Finger, thumb	3	159.40	4
R466	Wrist, elbow, ankle	3	255.10	4
R467	Shoulder	4	318.90	6
R468	Knee	3	255.10	5
R469	Sacro-iliac	5	255.10	5
R514	Symphysis pubis	5	255.10	6
R470	Hip	5	510.20	8
R471	Foot — interphalangeal	3	95.70	4
E575	— each additional		25.50	
R474	— mid-tarsal, sub-talar	3	223.20	4
R513	— triple	3	255.10	5
R475	— pan-talar, one stage	3	471.90	6
R477	— metatarsophalangeal	3	171.60	4
	Repair			
	Recurrent dislocations			
R400	Elbow	3	223.20	4
R401	Shoulder — all types	5	255.10	5
R402	Ankle, subluxation	4	255.10	5
R403	Patella	4	255.10	5
	Congenital dislocation — Hip			
R404	— closed reduction — with or without anaesthetic — unilateral		127.50	4
R405	— repeat manipulation and plaster		63.80	4
R406	— open reduction — simple or rotation osteotomy ..	7	255.10	7
R407	— acetabuloplasty (includes hip reduction)	7	255.10	7
R515	Knee — open	4	318.90	6

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		Asst.	Surg.	Anaes.
		\$		
	JOINTS — Cont'd			
	Ligaments			
R601	Metacarpophalangeal — early or late	3	159.40	4
	Elbow, wrist, ankle			
R597	— early simple/one ligament	3	127.50	4
R548	late/extensive/multiple/ligaments	3	301.20	4
R593	Shoulder cuff — simple repair	4	203.10	5
R594	— reconstruction	4	318.90	5
	Acromio, sternoclavicular			
	— early repair — see Dislocations			
R596	— late repair	4	205.50	4
R599	Knee — early repair — simple, one ligament	3	242.30	4
R542	— late/extensive and/or multiple ligaments (including synthetic substitution)	3	381.70	4
R484	— prosthetic anterior or posterior cruciate ligament insertion	6	339.70	6
R539	— removal of synthetics	4	159.40	4
	Foot deformity, club foot, etc.			
R408	— operative — medial release and tendon lengthening	4	191.30	4
R448	— arthrodesis and tendon transfers	4	255.10	4

REDUCTION, MANIPULATION

Dislocations

Upper Extremity

Finger

D001	— closed reduction — one	28.70	4
E576	— each additional	6.40	
D003	— open reduction	3 95.70	4

Metacarpophalangeal

D004	— closed reduction — one	28.70	4
E577	— each additional	6.40	
D006	— open reduction	3 95.70	4

Wrist and Carpal bones

D007	— closed reduction	79.70	4
D008	— open reduction	3 136.60	4

Elbow

D009	— closed reduction	49.00	4
D010	— open reduction	3 136.60	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code	REDUCTION, MANIPULATION - Cont'd	Asst.	Surg. \$	Anaes.
	Radial Head			
U.V.C.	— no reduction		visit fees	
D012	— closed reduction, pulled elbow		25.50	4
D011	— open reduction — acute	3	127.50	4
R540	— recurrent	3	159.40	5
R558	— late	4	255.10	6
	Glenohumeral Joint			
	— closed reduction			
D015	— without anaesthetic		31.90	
D016	— with anaesthetic		63.80	4
D017	— open reduction — early	4	191.30	6
D018	— late	4	382.60	7
	Acromio clavicular			
U.V.C.	— closed reduction		visit fees	
D021	— with pin fixation	4	95.70	4
D023	— open reduction with or without pin fixation	4	129.60	4
	Sterno clavicular			
	— closed reduction			
D024	— without anaesthetic		44.60	
D025	— with anaesthetic		95.70	4
D026	— open reduction	4	127.50	4
	Lower Extremity			
	Toe, interphalangeal			
D027	— closed reduction — with or without anaesthetic .		28.70	4
E578	— each additional		6.40	
D029	— open reduction	4	79.70	4
	Metatarsophalangeal			
D030	— closed reduction — with or without anaesthetic .		28.70	4
E579	— each additional		6.40	
D032	— open reduction	4	79.70	4
	Tarsal			
D033	— closed reduction		79.70	4
D034	— open reduction	4	143.50	4
	Ankle, dislocation			
D035	— closed reduction, with or without anaesthetic .		54.20	4
D036	— open reduction	4	127.50	4
	Knee			
D038	— closed reduction		127.50	4
D039	— open reduction	5	191.30	5
	Patella			
D040	— closed reduction — without anaesthetic		38.50	4
D031	— with anaesthetic		63.80	4
D041	— open reduction — early		127.50	5
D037	— late	4	191.30	6

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code	REDUCTION, MANIPULATION - Cont'd	Asst.	Surg.	Anaes.
		\$		
	Hip			
	anterior or posterior dislocation			
D042	— closed reduction, with or without anaesthetic		191.30	4
D043	— open reduction	7	255.10	7
Note:	For congenital dislocation of the hip, see page 147.			
	anterior and posterior fracture dislocation			
D051	— closed reduction	4	191.30	4
D052	— open reduction	7	318.90	7
	central dislocation — includes acetabular fracture			
U.V.C.	— no reduction		visit fees	
D044	— closed reduction, with or without anaesthetic		191.30	4
D045	— open reduction — lips	7	318.90	7
D046	— one pillar	4	637.70	7
D047	— two pillars	7	956.60	10
	Sacro-iliac			
D059	— closed reduction, traction, spica, etc.		318.90	5
D060	— open reduction	5	446.40	5
	Sacro-coccygeal			
U.V.C.	— non-operative		visit fees	
D061	— open reduction, removal of coccyx	5	127.50	5
	Temporo-mandibular joint			
D062	— closed reduction		31.90	4
D063	— open reduction	5	159.40	5
	Manipulation I.O.P.			
	Manipulation of joints under general anaesthetic			
Z222	Wrist, elbow, ankle, foot and T.M. joint, hand		19.30	4
Z223	Shoulder, knee, hip and spine		31.90	4
	Congenital foot deformity, club foot, etc.			
	non-operative			
Z244	— Denis Browne splint strapping		12.75	
	— manipulation and cast			
Z224	— with anaesthetic		25.50	4
Z235	— without anaesthetic — unilateral		12.75	
	BURSAE			
	Incision			
Z225	Aspiration (I.O.P.)		12.75	
Z226	Drainage, abscess (I.O.P.)		63.80	4
R502	Incision for removal of calcium	3	108.40	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code	BURSAE - Cont'd	Asst.	Surg.	Anaes.
	Excision		\$	
R506	Olecranon, prepatellar bursa	3	82.90	4
R507	Humero — radial	3	82.90	4
R590	Trochanteric or sub-acromial (Deltoid) bursa	3	127.50	4
	Biopsy			
R511	Superficial bursa		26.30	4
R512	Deep bursa	3	63.80	4
	MUSCLES			
	Incision			
Z227	Intramuscular abscess or haematoma (I.O.P.)		63.80	4
R517	Removal of foreign body, general anaesthetic, simple ..		26.30	4
R518	— complicated e.g., gunshot wound (see Preamble, Part B, paragraph 22)			
			I.C.	I.C. by region
	Release or cutting of muscle (myotomy)			
R519	— "tennis elbow"	4	63.80	4
R520	— scalenus anticus	5	265.70	5
R521	— muscle release, major	5	203.10	5
R516	— patellar retinaculum	5	95.70	5
	Excision			
Z228	Biopsy (I.O.P.)		63.80	4
Z245	Biopsy for malignant hyperthermia, three or more (I.O.P.)		95.70	8
R526	Resection of muscle (myectomy), e.g., sternomastoid ..	5	191.30	5
	Lesions of muscle and fascia			
R522	— simple excision (see Preamble, Part B, paragraph 22)		I.C.	I.C.
R523	— radical excision (see Preamble, Part B, paragraph 22)		I.C.	I.C.
R524	Excision of myositis ossificans	4	210.10	5
	Suture of laceration			
R525	Simple muscle repairs(s), to include repair of involved skin	3	56.70	4
R528	Complex muscle repair (see Preamble, Part B, paragraph 22)	4	I.C.	6
	Repair and Reconstruction			
R527	Total muscle transplant, e.g., pectoralis major	6	252.10	6
R529	Recession of muscle	3	102.00	4
R530	Quadricepsplasty	4	255.10	5

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code	MUSCLES — Cont'd	Asst.	Surg.	Anaes.
			\$	
R583	Steindler flexoplasty	3	223.20	5
R591	Muscle slide — forearm	4	191.30	5
R592	— quadriceps	4	255.10	6
R531	Facial paralysis — static slings	4	191.30	5
R532	— dynamic slings	4	251.55	6
R533	Composite repair for facial paralysis, plication of paralyzed muscles, and resection for paralysis of over active muscles	4	322.40	7
E597	— with meloplasty, add		53.10	

TENDONS AND FASCIA

Incision				
R534	Exploration of tendon or sheath	3	81.50	4
R535	Tenosynovitis, finger		81.50	4
R538	Exploration of fascia		81.50	4
Tenotomy or fasciotomy (closed) (I.O.P.)				
Z247	— finger — one		31.90	4
Z248	— two		47.80	4
Z249	— three or more		63.80	4
Z229	— toe — one		31.90	4
Z230	— two		47.80	4
Z243	— three or more		63.80	4
Z231	— palmar or plantar fascia		47.80	4
Z232	— hip adductors		31.90	4
Z237	— knee — one		31.90	4
Z238	— two		47.80	4
Tenotomy or fasciotomy (open)				
R536	— finger — one		56.70	4
R575	— two		81.50	4
R576	— three or more		127.50	4
R579	— toe — one		56.70	4
R580	— two		81.50	4
R581	— three or more		127.50	4
R546	— palmar or plantar (e.g. Steindler release)	3	63.80	4
R537	— wrist or forearm	3	81.50	4
R495	— forearm or leg for compression syndrome, one or more components (not to include secondary suture or graft)	3	147.10	4
Z251	— insertion of pressure monitoring device		31.90	
U.V.C.	— monitoring of pressure monitoring device		visit fees	
R544	— anterior/posterior tibial or Achilles tendon			
	— open	3	63.80	4
R555	— closed		31.90	4
Z233	— hip adductors (I.O.P.)		63.80	4
R543	— hamstrings — single	3	79.70	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code		Asst.	Surg.	Anaes.
TENDONS AND FASCIA - Cont'd				
R562	— multiple		\$	
R564	— knee (with release of tendon) — one	3	95.70	4
R566	— two	3	63.80	4
R545	— iliopsoas	3	95.70	4
R561	— iliotibial band	5	159.40	5
Z234	— biopsy, through incision (I.O.P.)	3	159.40	4
	Excision		35.40	4
	Ganglion			
R549	— simple			
R553	— complex, extensive	3	63.80	4
R551	Fascia for Dupuytren's — simple	3	I.C.	4
R552	— complex (with or without flaps or grafts)	3	127.50	4
Note:	R552 — includes necessary Z-plasties for release of the skin, radical excision of the palmar fascia and release of tendons and tendon sheaths with extension into the fingers, as required.	3	255.10	5
R550	Tendon sheath — single	3	177.15	4
E572	— each additional		56.70	1
			(max)	
	Repair — tendons			
	Tenolysis (extensive, including release of adhesions and/or repair of sheath)			
R556	— one			
E599	— each additional	3	127.50	4
			56.70	
	Tenoplasty (shortening, lengthening, etc.)			
R557	— one			
E050	— each additional	3	127.50	4
			56.70	
	Tendon suture			
	— finger, hand, wrist, foot, ankle			
R578	— extensor — single			
E580	— each additional	3	81.50	4
R585	— flexor — single		31.90	
E581	— each additional	3	141.70	4
	— biceps, Achilles, patellar, quadriceps, etc.		56.70	
R589	— early repair	3	136.60	4
R587	— late repair	3	255.10	4
	Insertion of silicone rod in flexor tendon space (includes tenolysis as necessary)			
R554	— one			
E051	— each additional	3	191.30	4
R586			77.90	
R559	Reconstruction of a flexor tendon pulley, per finger		63.80	4
E052	Tendon graft — hand or wrist — one	3	203.10	4
	— each additional		81.50	1
			(max)	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

		Asst.	Surg.	Anaes.
Code	TENDONS AND FASCIA — Cont'd		\$	
R560	— other location — one	4	159.40	4
E053	— each additional		56.70	1
			(max)	
	Tendon transfer			
R563	— hand, forearm — single	3	191.30	4
E054	— each additional		56.70	1
			(max)	
R567	— shoulder — pectoralis minor	4	223.20	4
R568	— trapezius	4	223.20	4
R569	— hip — abductor	5	255.10	6
R570	— iliopsoas	5	382.60	6
R571	— knee — one	3	203.10	5
E049	— each additional, add		56.70	1
			(max)	
R565	— foot, ankle — single	3	159.40	4
E055	— each additional		56.70	1
			(max)	
R572	— Foot, tendodesis	3	159.40	4
	Repair of Mallet finger			
U.V.C.	— closed		visit fees	
R574	— closed — using K Wire		63.80	4
R573	— operative	3	95.70	4
U.V.C.	Boutonniere — closed		visit fee	
R577	— open	3	95.70	4
R582	— late	3	159.40	4
	Repair — fascial defects			
	Thigh or forearm (sole procedure)			
R632	— simple	3	127.50	4
R633	— extensive, with or without synthetic graft or rotation flap	4	255.10	5
	EXTREMITIES			
R605	Debridement and plastic repair of traumatically amputated extremities (see Preamble, Part B, paragraph 22)	I.C.	I.C.	I.C.
R603	Digital reimplantation involving microvascular and neuroanastomosis	8	1027.50	8
R604	— revision of reimplanted digit (see Preamble, Part B, paragraph 22)	I.C.	I.C.	I.C.
R602	Pollicization	6	382.60	6

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Code	EXTREMITIES - Cont'd	Asst.	Surg.	Anaes.
	Amputation		\$	
	Upper Extremity			
R606	Through phalanx		95.70	4
E582	— each additional		31.90	
R608	Through metacarpal or M-P joint		127.50	4
E583	— each additional		31.90	
R610	Trans-metacarpal amputation of index or little finger		191.30	4
R611	Of hand — through all metacarpals	3	191.30	4
R612	**At wrist	4	191.30	5
R613	**Through radius and ulna	4	191.30	5
R614	**At elbow	4	191.30	5
R615	**High humerus	4	191.30	5
R616	**Shoulder disarticulation	4	191.30	5
R617	Forequarter (scapula)	9	255.10	9
	Lower Extremity	10	318.90	15
R618	Through phalanx	4	95.70	4
E584	— each additional		31.90	
R620	Metatarsal/phalanx disarticulation	4	95.70	4
E585	— each additional		31.90	
R621	Ray (single)	4	143.50	4
R622	**Transmetatarsal/transtarsal	4	143.50	4
R623	**Symes	5	191.30	5
R619	Terminal Symes	4	95.70	4
R624	**Through tibia and fibula	5	191.30	5
R625	**At knee — Gritti-Stokes or Callander	5	191.30	5
R626	**Through femur	5	191.30	5
R630	**Hip disarticulation	10	318.90	10
R631	Hemipelvectomy — hindquarter	10	510.20	15
**Note:	For the supervision of the limb fitting and 6 months post-operative care, claim visit benefits. Amputation with immediate fitting to include supervision of final limb fitting — add 40% (E586).			



SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

Code		Asst.	Surg. \$	Anaes.
NOSE				
Z298	E.U.G.A. of nasopharynx (I.O.P.) — if only procedure performed		28.30	4
Z297	Insertion of prosthesis for nasal septal perforation (I.O.P.)		12.40	
Endoscopy				
Z296	Fibreoptic endoscopy of upper airway (nasopharynx, hypopharynx or larynx) (I.O.P.) — if only procedure performed		7.80	
Incision (I.O.P.)				
Z301	Drainage of abscess or haematoma of septum		23.40	4
Z302	Turbinectomy		39.00	4
Excision				
Nasal polyp, papilloma (I.O.P.)				
Z304	Local anaesthetic — single		14.20	
Z305	— multiple (unilateral)		21.25	
Z306	General anaesthetic — single		28.30	4
Z307	— multiple (unilateral)		39.00	4
Z308	— single choanal polyp, papilloma		39.00	4
Septum				
M012	Submucous resection including septoplasty		166.50	4
Note:	All procedures (including I.O.P.) connected with S.M.R. such as nasal polypectomy, turbinectomy, ethmoidectomy, etc. — add 50% of the listed benefit(s) for the other procedure(s).			
M013	Partial septorhinoplasty (excluding osteotomies)		251.55	7
M014	Septorhinoplasty		301.15	7
M019	— with autologous bone or cartilage graft		531.45	7
R319	Graft — autologous, bone or cartilage	4	251.55	4
R320	— non-autologous — prosthetic implant	4	163.00	4
Note:	M013, M014, M019, R319, R320 — claims for these procedures require O.H.I.P. authorization. (See Surgical Preamble, paragraph (17)).			
M015	Septodermoplasty		194.90	4
M016	Closure of septal perforation		194.90	4
M017	Localization of cerebrospinal rhinorrhea (fluorescein injection)		58.45	4
M018	Narrowing operations or implant for atrophic rhinitis — unilateral		194.90	4

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

Code		Asst.	Surg.	Anaes.
		\$		
	NOSE — Cont'd			
	Excision of choanal atresia			
M020	Anterior nasal approach			
	— uni or bilateral	4	251.55	4
M021	Puncture and insertion of tube only		63.80	4
M022	Transpalatal approach — uni or bilateral	5	251.55	6
	Biopsy (I.O.P.)			
Z309	— local anaesthetic		11.70	
Z310	— general anaesthetic		28.30	4
	Repair			
M028	Choanal atresia, uni or bilateral			
	— dilation		37.20	4
M029	— repeat within 30 days		23.00	4
M030	Rhinoplasty for reconstruction of cleft lip nasal deformity in adolescence or adulthood	4	361.40	7
	Removal of foreign body (I.O.P.)			
Z311	— simple		7.10	
Z312	— complicated, or involving general anaesthesia		28.30	4
	Destruction			
Z313	Cauterization of turbinates (I.O.P.) unilateral or bilateral		24.80	4
Z300	Cryosurgery of turbinates (I.O.P.) unilateral or bilateral		39.00	4
	Treatment of Epistaxis			
Z314	Cauterization of nasal septum — chemical or electrocautery (I.O.P.) — unilateral		7.10	4
Z315	Anterior packing (I.O.P.) — unilateral		7.80	4
Z316	Anterior and posterior packing only (I.O.P.) — bilateral		24.80	4
M027	Ligation of external carotid artery	6	106.30	6
	ACCESSORY NASAL SINUSES			
	Antrum or sinus lavage (I.O.P.)			
Z317	Proetz displacement		3.90	
Z318	Local anaesthetic — unilateral		17.70	
Z319	General anaesthetic — unilateral or bilateral		28.30	4
	Sinusotomy, sinusostomy, sinusectomy as indicated			
M054	Maxillary, intranasal — unilateral	4	81.50	4
M055	— radical, Caldwell-Luc — unilateral (includes M054)	4	155.90	4

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

		Asst.	Surg.	Anaes.
Code	ACCESSORY NASAL SINUSES – Cont'd		\$	
M056	Maxillectomy	7	389.70	10
	Frontal			
M057	— trephine and sinusectomy		113.40	4
M058	— radical		311.80	5
M059	— external fronto-ethmoidal with sphenoid if necessary	4	311.80	6
	Ethmoidal			
M060	— intranasal — unilateral		102.70	4
M023	— external — unilateral	4	251.55	4
M061	Sphenoidal — intranasal		131.10	4
M062	Vidian neurectomy — uni or bilateral	4	233.80	4
	Suture			
M066	Closure of antro-oral fistula			
	— very simple		42.50	4
M067	— with Caldwell-Luc		226.75	5
M068	— with palatal flap		251.55	5
	LARYNX			
	Endoscopies (I.O.P.)			
Note:	When laryngoscopy and bronchoscopy are carried out as combined procedures, the physician may claim for one or the other but not both.			
	Laryngoscopy			
Z321	Direct — with or without biopsy		39.00	6
Z322	— with removal of foreign body		74.40	6
Z323	— with removal of lesion(s)		102.70	6
Z343	— with dilation of larynx and bronchoscopy . . .		141.70	6
Z324	Indirect — with biopsy		23.00	6
Z325	— with simple removal of bone		11.70	6
E600	Using operating microscope — add to charges for laryngoscopy (i.e.: to Z321-Z323, Z327, Z328, Z330, Z342, Z343, Z348)		24.80	
	Introduction			
M080	Injection of teflon for abductor paralysis		127.50	6
	Excision (to include laryngoscopy)			
M081	Laryngectomy — total	6	425.20	13
M082	— partial (Laryngofissure)	6	251.55	8
M084	— hemilaryngectomy	6	389.70	9
M085	Arytenoidectomy	6	251.55	8
M091	Arytenoidopexy		251.55	8
	Repair (to include laryngoscopy)			
M090	Laryngoplasty (see Preamble, Part B, paragraph 22) . . .		I.C.	6

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

		Asst.	Surg.	Anaes.
Code	LARYNX - Cont'd		\$	
M089	Creation of tracheo-esophageal fistula	3	106.30	4
Z320	Insertion of voice prosthesis (I.O.P.)		17.70	
	TRACHEA AND BRONCHI			
	Endoscopy (I.O.P.)			
Notes:	(1) When laryngoscopy and bronchoscopy are carried out as combined procedures, the physician may claim for one or the other but not both.			
	(2) No claim should be made for bronchoscopy carried out immediately following thoracic surgery under the same anaesthetic by the same surgeon.			
	Bronchoscopy			
Z327	— with or without bronchial biopsy, suction or injection of contrast material		77.90	6
Z328	— with removal of foreign body		102.70	6
Z350	— with dilatation of stricture		109.80	6
Z351	— with selective endobronchial blocker or catheter insertion		109.80	6
Z352	— with palliative endobronchial tumour resection including laser or cryotherapy		124.00	6
Z342	— all 18 segmental with multiple concomitant random bronchial biopsies or brushings labelled as to site . .		124.00	6
	Tracheo-bronchial toilet (I.O.P.)			
Z344	First procedure		23.40	
Z345	Subsequent procedures performed by same physician . .		11.70	
	(Not to apply to operating surgeons, when respiratory unit benefits apply, or within the first two hours post-operatively.)			
Z326	Change of tracheostomy tube		7.10	
Z346	Transtacheal aspiration		13.80	
	Incision (I.O.P.)			
Z741	Tracheostomy	3	95.70	5
Z738	Insertion of Montgomery "T" Tube — for tracheal or laryngo-tracheal stricture (including bronchoscopy and dilatation)	4	131.10	8
	Excision			
M102	Segmental resection of cervical trachea	9	513.70	10
M103	Resection of mediastinal trachea with either sternotomy or thoracotomy	9	779.50	13
M104	Carinal resection (without pulmonary resection)	11	1009.75	15
	Repair			
M100	Tracheal rupture, transcervical	9	403.90	10

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

Code		Asst.	Surg.	Anaes.
	TRACHEA AND BRONCHI - Cont'd		5	
M101	Tracheal-bronchial rupture, transthoracic	9	531.45	13
	CHEST WALL AND MEDIASTINUM			
	Excision			
M105	Chest wall tumour resection of 2 or 3 ribs or cartilages with reconstruction of chest wall	9	318.90	13
E601	— for each additional rib (more than 3) to a maximum of 3 additional, add		35.40	
E602	— with sternal resection, add		106.30	
M107	Total sternectomy with reconstruction	9	460.60	13
N284	Excision of first rib-complete		265.70	6
E603	— with cervical rib, add		53.10	
M106	Mediastinal tumour	9	396.80	13
	Repair			
	Chest wall (see Preamble, Part B, paragraph 22)			
M109	pleura — closed		I.C.	5
M110	— open		I.C.	13
M116	Chest wall fixation for trauma	4	223.20	6
E604	— for fixation of each additional rib exceeding four ribs, add		35.40	2
M117	Sternal fixation for trauma	4	159.40	6
	Surgical Collapse			
M111	Thoracoplasty — one stage	9	194.90	10
E605	— for each additional rib (more than 3) to a maximum of 3 additional, add		35.40	
Z742	Phrenicotomy (I.O.P.)	3	63.80	5
	Incision			
Z353	Incisional biopsy of chest wall tumour (I.O.P.)	3	56.70	4
Z354	Excisional biopsy of rib for tumour (I.O.P.)	4	85.00	6
M118	Thoracic window creation	5	141.70	7
M119	Thoracic window closure	4	70.90	6
	Endoscopies (I.O.P.)			
Z329	Mediastinoscopy		116.90	6
Z330	with bronchoscopy		155.90	
Z348	with bronchoscopy and mediastinotomy		219.70	
Z347	Anterior mediastinotomy — when sole procedure performed	3	124.00	6
	LUNGS AND PLEURA			
	Introduction — Thoracentesis (I.O.P.)			
Z331	Aspiration for diagnostic sample		15.60	

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

Code		Asst.	Surg. \$	Anaes.
LUNGS AND PLEURA – Cont'd				
Z332	Aspiration with therapeutic drainage with or without diagnostic sample		28.30	4
E606	Administration of chemotherapy, add		6.40	
Z334	Total Unilateral lung lavage with or without bronchoscopy using double lumen tube and single lung anaesthesia		180.70	13
Endoscopy (I.O.P.)				
Z335	Thoracoscopy or pleuroscopy, with or without pleural biopsy, suction etc		70.90	5
Z349	Transbronchial lung biopsy(s) including bronchoscopy ..		109.80	6
Incision				
Z340	Biopsy of lung, needle (I.O.P.)		46.05	4
Z336	Biopsy of pleura, needle (I.O.P.)		27.30	4
Z341	Closed drainage — effusion or pneumothorax (I.O.P.) ..		39.00	4
Z337	Rib resection for drainage (I.O.P.)	6	77.90	6
M133	Thoracotomy for removal of foreign body	9	240.90	13
M137	Thoracotomy with or without biopsy	9	240.90	13
M134	Thoracotomy for post-operative haemorrhage or empyema	9	240.90	13
M132	Thoracotomy with repair of ruptured diaphragm	9	311.80	13
M130	Closure of broncho-pleural fistula (transthoracic or trans-sternal)	9	336.60	13
E609	— with intercostal muscle bundle, add		77.90	
E610	— with myovascular flap (pectoralis major, latissimus dorsi, rectus abdominis, add		166.50	
M135	Major decortication of lung for empyema or tumour	11	336.60	15
E611	— with myovascular flap, add		166.50	
Z339	Intercostal drainage with insufflation of sclerosing agent under general anaesthesia (I.O.P.)	4	116.90	6
Excision				
Z338	Biopsy of pleura or lung — with limited thoracotomy (I.O.P.)	9	127.50	13
M138	Hilar lymphnode or lung biopsy with full thoracotomy ..	9	255.10	13
M142	Pneumonectomy — complete	10	584.60	14
E612	— total extra-pleural pneumonectomy, add		74.40	
E613	— sleeve pneumonectomy, add		152.30	
E614	— omental graft, add		102.70	
E615	— intra-pericardial dissection, add		49.60	

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

Code		Asst.	Surg.	Anaes.
	LUNGS AND PLEURA - Cont'd		\$	
M143	Lobectomy	10	584.60	13
E616	— bi-lobectomy on right side, add		88.60	
E617	— with pleural tent, add		49.60	
E618	— with decortication of remaining lobe(s)		74.40	2
E619	— sleeve lobectomy, add		102.70	
E620	— with wedge bronchoplasty, add		49.60	
E621	— with diagnostic wedge resection, add		24.80	
M144	Segmental resection, including segmental bronchus and artery	10	584.60	13
M145	Wedge resection of lung	10	272.80	13
E608	— each additional (to a maximum of three)		39.00	
M151	Bullectomy for major bullous disease	10	389.70	13
M149	Pleurectomy, and/or apical bullectomy for pneumothorax	10	272.80	13
E607	Re-operation, (more than 30 days subsequent to previous excision) add to appropriate excision benefit		95.70	



SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

		Asst.	Surg.	Anaes.
			\$	
Code R700	(a) with hypothermia and without bypass — basic fee for cardiovascular procedures			25
Note:	This code REPLACES PROCEDURAL BASIC code when hypothermia is used where basic is less than 25 units.			
E650	(b) pump bypass — extra to surgeon's fee		230.30	
R702	(bypass includes cannulating and decannulating heart or major vein, major artery, supervision of pump and pump run.) (anaesthetist see Preamble, part B, paragraph 33(h))			28
Z743	(c) circulatory assist device e.g. intra-aortic balloon (includes cannulation, post operative daily care and supervision) (I.O.P.)		184.20	5
Z744	(d) decannulation of circulatory assist device (I.O.P.) ..		74.40	5
Z751	(e) repositioning of intra-aortic balloon pump (no claim to be made for repositioning within 24 hours of original insertion)		77.90	5
E655	(f) re-operation for failed vascular grafts — for repair or replacement of existing prosthesis (more than one month after original operation) add to appropriate benefit		106.30	
Z759	(g) Removal of failed vascular graft (I.O.P.) — without arterial reconstruction		116.90	6
E658	(h) re-operation involving open heart procedures with pump (more than one month after initial operation) add to appropriate benefit		141.70	
	(i) Preliminary diagnostic catheterization — extra to operative benefits. (see Diagnostic and Therapeutic Procedures)			
	(j) The basic anaesthetic benefit of 28 units for major cardiovascular surgery includes such procedures as C.V.P. line (G268), arterial line, taking arterial blood samples, doing blood gases and interpreting results.			

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

Code	HEART AND PERICARDIUM	Asst.	Surg.	Anaes.
		\$		
Note:	The benefit for gas endarterectomy of a coronary artery is the same as for coronary endarterectomy.			
	Cardiac massage			
	— closed (see Resuscitation on page 93.)			
R765	— open	13	134.60	13
R752	Atrio-ventricular sequential pacemaker with permanent atrial and ventricular endocardial electrodes	4	283.40	5
R751	Implantation of epicardial electrode(s) plus implantation of pack	6	290.50	20
Z411	Replacement of pack (I.O.P.)	3	88.60	5
Z412	Replacement or repair of pacemaker lead (I.O.P.)	3	63.80	5
M137	Thoracotomy — with or without biopsy	9	240.90	13
M134	— for post-operative hemorrhage	9	240.90	13
Z401	Aspiration of pericardium (I.O.P.)		42.50	
R750	Open biopsy of pericardium and drainage (transthoracic or epigastric)	13	194.90	13
R748	Pericardiectomy — one side open	13	396.80	20
R749	— both sides open or sternal split	13	630.65	20
R712	Cardiotomy with exploration	18	322.40	20
R713	— with removal of foreign body	18	396.80	20
R714	— with removal of tumour	18	322.40	20
	— electrophysiologic mapping of heart			
E660	— epicardial, add		81.50	
E661	— endocardial and/or HIS Bundle, add		163.00	
E662	— division of accessory conduction pathways, add		39.00	
R920	Excision — ventricular tumour	18	421.60	28
R746	— ventricular aneurysm	18	566.90	28
R747	— aneurysm of sinus of Valsalva	18	510.20	28
R741	Coronary — endarterectomy	18	460.20	20
E651	— when done in conjunction with coronary artery repair, add		124.00	
R742	Coronary artery repair (aorto-coronary bypass graft) — one	18	584.60	20
R743	— two	18	761.70	20
E654	— each additional		124.00	
	Implantation of internal mammary			
E652	— done in conjunction with coronary artery repair, add		120.50	
R739	— sole procedure — single	18	460.60	20
R740	— double	18	566.90	20

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

Code		Asst.	Surg. \$	Anaes.
	HEART AND PERICARDIUM - Cont'd			
	Ligation or division patent ductus			
R754	— infant or child	13	322.40	20
R755	— adolescent or adult	13	478.30	20
	Interruption of bronchial collateral arteries (one or more arteries)			
R857	— sole procedure	13	478.30	20
E663	— when done in conjunction with other cardiac surgery, add		113.40	
R757	Resection coarctation — infant	13	414.50	20
R756	— child	13	396.80	20
R758	— adolescent or adult	13	527.90	20
R759	Congenital heart procedures — e.g. Blalock, Glenn, Potts, Waterston or Central	13	396.80	20
R763	Creation of ASD — by balloon septostomy	9	194.90	9
R762	— by thoracotomy or Sterling Edwards	18	396.80	20
R715	Closure atrial septal defect: secundum	18	396.80	20
R716	— endocardial cushion and valve defect	18	612.90	20
R717	— with anomalous pulmonary venous drainage	18	517.30	28
R718	Closure of ventricular septal defect	18	517.30	28
	Repair			
	Total repair Tetralogy of Fallot			
R720	— with or without previous arterial shunt	18	690.90	28
R722	Total anomalous pulmonary venous drainage	18	612.90	28
R723	Total correction transposition of great vessels	18	612.90	28
R721	Arterial repair of transposition	18	921.20	28
R921	Complete A-V canal	18	807.80	28
R922	Single ventricle	18	921.20	28
R923	Double outlet — right/left ventricle	18	807.80	28
R924	Double outlet ventricle with transposition	18	921.20	28
R925	Truncus arteriosus	18	921.20	28
R926	Interrupted aortic arch	18	807.80	28
R927	Aorto-pulmonary window	18	517.30	28
R928	R-V outflow tract with valve and tubular graft	18	577.50	28
R929	Debanding arterioplasty of pulmonary artery	18	517.30	28
R768	Pulmonary artery banding	13	322.40	20
R769	— with pressure studies by anaesthetist, extra/hour			5
R770	Correction of cor triatriatum	18	453.50	20
R771	Vascular ring	18	396.80	20
	VALVES			
R724	Pulmonary valvotomy	18	396.80	28
R725	Pulmonary valvotomy and infundibular resection	18	453.50	28

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

Code		Ast.	Surg.	Anaes.
	VALVES — Cont'd		\$	
R772	Pulmonary valve replacement	18	453.50	28
R726	Tricuspid valvotomy	18	425.20	20
R727	Tricuspid annuloplasty	18	396.80	20
R728	Tricuspid valve replacement	18	453.50	28
R729	Mitral valvotomy	18	432.20	20
R730	Mitral valvotomy — restenosis	18	496.00	20
R734	Mitral annuloplasty	18	581.05	20
R735	Mitral replacement	18	581.05	28
R930	Aortic valvuloplasty	18	520.80	28
R736	Aortic valvotomy	18	425.20	20
R737	Aortic infundibular resection (ventriculomyotomy)	18	538.50	28
R738	Aortic valve replacement	18	627.10	28
R863	Replacement of aortic valve, replacement of ascending aorta, and re-implantation of coronary arteries (modified Bentall procedure)	18	1328.60	28
Note:	Multivalvular replacement — (R728, R735, R738, R772) — the benefit will be that for the major valve replaced plus 85% of the benefit for the additional valve or valves.			
	ARTERIES			
	Cannulation for infusion chemotherapy			
R775	— superficial temporal artery	3	58.45	4
R776	— hepatic artery	6	131.10	6
R778	— carotid	5	88.60	5
R782	Gas embolization of peripheral arteries		27.30	
R760	Regional isolation perfusion e.g. iliac	10	251.55	10
R764	Exploration of major artery	6	170.10	I.C.
	Incision			
Z402	Arteriotomy (I.O.P.)		70.90	4
Note:	Not allowed in addition to other major cardiovascular surgery when performed at same time.			
	Repair — traumatic			
	Lacerated major artery			
R790	— suture	4	194.90	4
R795	— including patch angioplasty	10	308.20	10
R862	— by interposition graft or bypass graft	10	407.40	10
	Ligation			
R781	Ligation of artery — by region etc.*	3	63.80	I.C.*
R788	— internal maxillary artery (Caldwell Luc approach) .	7	251.55	10
R789	— anterior ethmoid artery	6	95.70	6
R708	— internal iliac artery (uni or bilateral)	7	251.55	10

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

Code	ARTERIES — Cont'd	Asst.	Surg.	Anaes.
	Excision and/or Repair:		\$	
Notes:	(1) Repair of artery implies either endarterectomy and/or by-pass graft:			
	(2) The benefits listed for by-pass grafts include endarterectomy and/or thrombectomy of the artery being repaired			
Note:	For excision of glomus tumour see Z811 (page 218).			
R815	Arterioplasty with or without patch graft (other than listed below)	10	322.40	10
R792	Carotid — endarterectomy	10	460.60	10
R796	— carotid body tumour	10	460.60	10
R798	— aneurysm — reconstruction or excision with graft ..	10	496.00	10
	Aortic arch reconstruction			
R830	— Innominate	10	531.45	10
R831	— Subclavian	10	531.45	10
R832	— Vertebral	10	531.45	10
E659	— with thoracotomy, add	3	102.70	7
	Thoracic aorta aneurysm — repair or excision with graft			
R799	— ascending	10	885.75	20
R800	— arch	10	1098.30	20
R801	— descending, with or without temporary shunt	10	779.50	20
R802	Abdominal aorta — aneurysm	10	708.60	17
R816	— plus unilateral common femoral repair	10	779.50	17
R817	— plus bilateral common femoral repair	10	850.30	17
R803	— plus implantation of inferior mesenteric artery ...	10	814.90	17
R804	— ruptured	10	850.30	17
R818	— ruptured plus unilateral common femoral repair ..	10	921.20	17
R819	— ruptured plus bilateral common femoral repair ...	10	992.00	17
	Mesenteric or celiac artery repair			
R811	— aneurysm	10	251.55	10
R935	— removal of band only	10	251.55	10
Note:	Use R935 for excision of coeliac ganglion.			
R936	— endarterectomy or graft	10	531.45	10
	Aorto-Iliac repair			
R783	— including common iliac repair (uni- or bilateral) ...	10	620.00	17
R784	— plus unilateral common femoral repair	10	733.40	17
R785	— plus bilateral common femoral repair	10	814.90	17
R814	— embolectomy or thrombectomy of bifurcation (aorta or graft)	10	283.40	10
R858	— total removal of infected aortic graft (stem and limbs) (arterial reconstruction extra)	10	566.90	17
E664	— with closure of duodenum, add		77.90	
R859	— partial removal of infected aortic graft (one limb only) (arterial reconstruction extra)	10	212.60	10

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

Code		Asst.	Surg. \$	Anaes.
	ARTERIES — Cont'd			
R806	Renal artery repair	10	531.45	10
R805	Renal artery — aneurysm — reconstruction or excision with graft	10	531.45	10
R807	Splenic artery aneurysm — reconstruction or excision with graft	10	251.55	10
R786	Iliac repair (to include internal iliac aneurysm)	10	496.00	10
R937	Ilio-femoral bypass graft	10	496.00	10
	Per-obturator ilio-femoral graft			
R860	— with saphenous vein	10	552.70	10
R861	— with prosthetic graft	10	538.50	10
R855	Common femoral/profunda femoris repair (when sole procedure performed)	10	343.70	10
R856	Extended profundoplasty (profunda femoris)	10	481.80	10
Notes:	(1) Common femoral artery repair (eg. R784, R785) includes repair to the profunda femoris artery as far as the first major branch. (2) If the repair extends beyond the first major branch of the profunda femoris artery, R815 may be claimed in addition. (3) If the repair extends beyond the second major branch of the profunda femoris artery, R856 instead of R815 may be claimed in addition.			
R933	Axillo-femoral, femoro-femoral, femoral cross-popliteal or axillo-axillary graft	10	396.80	10
R934	Aorto-femoral unilateral graft	10	531.45	17
R808	Femoral aneurysm — reconstruction or excision with graft	10	372.00	10
R864	Repair of false aneurysm at groin anastomosis	10	549.20	10
R809	Femoral — popliteal endarterectomy	10	467.70	10
	Femoral — popliteal bypass graft with or without endarterectomy			
R791	— with saphenous vein	10	492.50	10
R794	— with prosthetic graft	10	474.80	10
	Femoro-anti/post. tibial/peroneal bypass graft with or without endarterectomy			
R787	— with saphenous vein	10	584.60	10
R780	— with prosthetic graft	10	549.20	10
R810	Popliteal aneurysm	7	496.00	10
	Peripheral arteries other than listed			
R812	— aneurysm	7	251.55	10
R813	— embolectomy or thrombectomy — artery or graft .	7	194.90	10
	VEINS			
R827	Creation of A V fistula	4	201.95	6
R848	Erasure and coagulation	3	63.80	4
Note:	R848 does not apply to minor veins and venules.			

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

Code	VEINS - Cont'd	Asst.	Surg.	Anaes.
		\$		
	Excision			
	Resection of A V aneurysm or fistula with or without major graft			
R825	— major aneurysm by region*	10	602.30 I.C.*	
R826	— minor aneurysm*	10	301.15 I.C.*	
R847	Stasis ulcer and skin graft — per leg	3	131.10	5
R845	Stasis ulcer, multiple ligation and skin graft — per leg . .	5	223.20	5
	Ligation			
Z745	Saphenous (IOP)		31.90	4
Z746	Femoral (IOP)	3	46.05	4
Z747	Popliteal (IOP)	3	46.05	4
Z748	Internal jugular (IOP)	5	92.10	5
R839	Internal iliac	6	240.90	10
R834	I.V.C. — transabdominal	6	272.80	10
R838	— transvenous	6	184.20	10
Note:	Use R838 for insertion Mobin Uddin Umbrella Filter.			
	Ligation, Avulsion, Electrocoagulation			
R837	Multiple	4	95.70	4
E656	— plus stripping, add		63.80	1
R844	And/or stripping — recurrent varicose veins	5	226.75	5
R842	Extra fascial and sub-fascial incompetent perforators by full fascial technique	5	233.80	6
E653	plus stripping add		77.90	
	Repair			
R820	Lacerated major vein	4	131.10	4
R835	SVC bypass graft	7	467.70	17
R836	Pulmonary embolectomy	18	531.45	20

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

Code		Asst.	Surg.	Anaes.
			\$	
	VEINS — Cont'd			
R828	Ilio-femoral thrombectomy with or without femoral vein ligation	10	272.80	10
E657	plus I.V.C. ligation, add		272.80	
R829	Thrombectomy other than above (see Preamble, Part B, paragraph 22)	I.C.	I.C.	I.C.
R865	Distal spleno-renal shunt	10	779.50	10
	Anastomosis			
R822	Porto-caval	10	566.90	10
R823	Spleno-renal — abdominal approach	10	690.90	10
R821	— transthoracic approach	10	690.90	13
R824	Meso-caval	10	531.45	10
R846	Micro lympholympho or lymphovenous anastomosis ...	7	425.20	7

SURGICAL PROCEDURES

OPERATIONS ON THE HAEMIC AND LYMPHATIC SYSTEMS

Code	SPLEEN AND MARROW	Asst.	Surg.	Anaes.
		\$		
	Incision (I.O.P.)			
Z404	Splenic puncture and aspiration		50.70	4
Z403	Bone marrow aspiration		21.10	
Z408	Bone marrow core biopsy (with biopsy needle)		39.00	4
Note:	(1) Z408 may not be allowed with Z403 (Not the same as Z403.)			
	(2) Bone marrow interpretation — see L802 Laboratory Medicine Schedule			
Z430	Bone marrow transplantation (aspiration from donor and infusion into recipient) — team benefit (I.O.P.)	7	354.30	8
Note:	Z430 — bone marrow transplantation is not a benefit of OHIP for treatment of some conditions. Please refer to OHIP District Office for qualifying diagnoses.			
	Excision			
R905	Splenectomy — partial or complete	7	301.15	7
	LYMPH CHANNELS			
	Excision			
R907	Cystic hygroma — unilateral	4	212.60	6
	Anastomosis			
R846	Micro lympholympho or lymphovenous anastomosis ...	7	425.20	7
	LYMPH NODES			
	Incision			
Z410	Drainage of sub-fascial abscess (I.O.P.)		46.05	4
	Excision			
R910	Neck — limited e.g. submandibular supra omohyoid ...	6	170.10	6
R911	— radical	6	375.55	8
R915	— modified radical including functional with preservation of spinal accessory nerve	6	425.20	8
R912	Ileinguinal, radical resection	6	301.15	8
	Axillary or inguinal nodes			
R913	— radical resection	4	226.75	6
R914	— limited resection	4	120.50	4

SURGICAL PROCEDURES

OPERATIONS ON THE HAEMIC AND LYMPHATIC SYSTEMS

Code		Asst.	Surg.	Anaes.
		\$		
	LYMPH NODES - Cont'd			
	Biopsy I.O.P.			
Z405	— cervical, axillary, inguinal	4	39.00	4
Z406	— scalene	4	77.90	4
Z578	— multiple para-aortic lymph nodes	6	46.05	6
	— percutaneous retroperitoneal			
Z407	— one group	4	53.10	4
Z409	— two or more groups	4	81.50	4
R916	Re-exploration of vascular graft and closure of lymph			
	fistula in groin	4	120.50	6

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code	MOUTH	Asst.	Surg.	Anaes.
		\$		
	Incision			
S001	Drainage of Ludwig's Angina		63.80	5
Z501	Biopsy (I.O.P.)		23.40	4
	Excision			
Z502	Simple excision of lesion (I.O.P.)	3	28.30	4
S004	Excision of ranula	3	106.30	4
S003	Excision of intra-oral tumour (greater than 2.0 cm average diameter)	4	148.80	6
S005	Composite resection of primary tumour, e.g. mouth, tongue, tonsil or pharynx plus ipsilateral mandible (Commando procedure)	10	340.10	12
E705	— with ipsilateral neck dissection, add		166.50	
	Cryosurgery for treatment of premalignant or malignant lesion(s) of oral cavity or sinuses			
S050	— minor — initial		58.45	4
S051	— repeat within 30 days		29.20	4
S052	— intermediate — initial		148.80	4
S053	— repeat within 30 days		74.40	4
S054	— major — initial		205.50	6
S055	— repeat within 30 days		102.70	6
	LIPS			
	Incision			
Z503	Biopsy (I.O.P.)		24.80	4
	Excision			
S011	Wedge resection of lip			
	— vermilion	3	46.05	4
S010	Wedge resection of lip with plastic repair	3	155.90	4
Z504	Excision of lesion (I.O.P.)	3	39.00	4
S012	Lip shave — vermillionectomy	3	127.50	4
	Repair			
S013	Cleft lip — unilateral	6	223.20	8
S014	Reconstruction with lip switch flap	6	283.40	8
S015	Complex reconstruction or revision of previous repair (see Preamble, Part B, paragraph 22)		I.C. I.C.	
	TONGUE			
	Incision			
Z505	Biopsy (I.O.P.)		17.00	4

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

		Asst.	Surg.	Anaes.
Code	TONGUE - Cont'd		\$	
	Tongue tie, release of — (I.O.P.)			
Z111	infant		9.60	
	child or adolescent			
Z112	— local anaesthetic		9.60	
Z113	— general anaesthetic		35.40	4
	Excision			
S018	Glossectomy — partial	6	127.50	8
S019	— complete	6	194.90	8
Z109	Wedge excision of lesion (I.O.P.)		42.50	4
	Repair			
S020	Glossoplasty	4	95.70	4
	Suture			
S021	Extensive laceration (see Preamble, Part B, paragraph 22)	4	I.C.	I.C.
	Minor laceration — see Skin.			
	TEETH AND GUMS			
	Incision			
Z506	Drainage of alveolar abscess, general anaesthetic (I.O.P.)		24.80	4
	Excision			
S023	Extraction of tooth (complete care) — single		12.40	4
E700	— each additional tooth		7.80	
S028	Dentigerous cyst	4	46.05	4
S900	Basic units for anaesthesia with any unlisted dental surgical procedure performed by a dental or oral surgeon (see also OHIP Bulletin #4069)			I.C.
	PALATE AND UVULA			
	Incision			
Z507	Palate abscess (I.O.P.)		23.40	4
S031	Fenestration of palate for radiotherapy			4
Z508	Biopsy of palate (I.O.P.)		17.00	4
	Excision			
Z509	Uvulectomy or biopsy of local lesion (I.O.P.)		17.00	4
	Repair			
S034	Cleft palate	6	226.75	8
S035	Removal of sutures			4
S032	Bone graft to palate	6	226.75	8

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code		Asst.	Surg. \$	Anaes.
	PALATE AND UVULA - Cont'd			
	Closure of fistula			
S030	— anterior alveolar	4	106.30	4
S033	— palate	6	180.70	6
	SALIVARY GLANDS AND DUCTS			
	Incision			
Z500	Sialolithotomy (I.O.P.)			
	— local anaesthetic		46.05	
Z521	— general anaesthetic	3	70.90	4
Z510	Biopsy (I.O.P.)	3	31.90	4
	Excision			
S042	Submaxillary gland	4	177.15	4
S043	Parotid gland — total (with preservation of facial nerve)	6	425.20	8
S044	— total (without preservation of facial nerve)	6	318.90	8
S045	— subtotal (with preservation of facial nerve)	6	364.90	7
S047	— repeat subtotal (with preservation of facial nerve)	6	425.20	7
S046	— subtotal (without preservation of facial nerve)	6	283.40	6
Z522	Excision small tumour (I.O.P.)	4	31.90	4
	Repair			
S049	Plastic repair of duct	4	141.70	4
Z511	Dilation of duct (I.O.P.)		22.00	4
S057	Submandibular duct relocation	6	251.55	6
	Probing			
Z512	Duct (I.O.P.)		7.80	
	PHARYNX, ADENOIDS AND TONSILS			
	Incision			
Z513	Drainage of retropharyngeal, intra-oral or peri-tonsillar abscess (I.O.P.)		31.90	4
S056	lateral pharyngeal	3	106.30	4
Z514	Biopsy of pharynx (I.O.P.)		23.40	4
	Excision			
S002	Excision of parapharyngeal space lesions (with mobilization of parotid gland if necessary)	4	357.80	8
S067	Pharyngectomy — trans-hyoid or lateral	8	389.70	11
S068	Pharyngo-laryngectomy	8	531.45	14
S058	Branchial — cyst	4	180.70	4
S059	— sinus	4	233.80	4
S060	— fistula	4	251.55	5
S061	Thyroglossal duct, cyst, sinus or fistula	4	212.60	4
S062	Recurrent procedure	4	283.40	4

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

		Asst.	Surg.	Anaes.
Code	PHARYNX, ADENOIDS AND TONSILS - Cont'd		\$	
S063	Tonsillectomy — Child		77.90	4
S064	— Adolescent or adult		99.20	4
	Tonsillectomy and Adenoidectomy — Same benefits as Tonsillectomy.			
S065	Adenoidectomy — Child or Adult		53.10	4
	Secondary suture or cauterization following T and A			
S066	When haemorrhage occurs after initial procedure and is treated surgically		35.40	4
	Repair			
S069	Pharyngoplasty	8	226.75	8
	OESOPHAGUS			
Note:	For procedures on the Oesophagus, the following basic units for assistants and anaesthetists will apply except if a basic benefit is listed:			
S073	Cervical approach	6		7
S074	Thoracic approach	10		13
S075	Abdominal approach	7		8
	Endoscopies (I.O.P.)			
Z515	Oesophagoscopy, with or without biopsy		49.60	4
Z516	with removal of foreign body		74.40	4
Z517	Oesophagoscopy with injection of varices — initial		88.60	4
Z518	— subsequent within 30 days		63.80	4
Z519	Oesophagoscopy with dilation		88.60	4
Z520	Oesophago-bronchoscopy with or without biopsy		92.10	6
Z567	Subsequent procedure (within three months following previous endoscopic procedure)		53.10	6
Z399	Oesophagoscopy, gastroscopy with or without duodenoscopy — elective		74.40	4
Z400	— for active bleeding		81.50	4
Z568	Subsequent procedure (within three months following previous endoscopic procedure)		49.60	4
E702	— with multiple (3 or more) biopsies of specific lesion, add		10.60	
E703	— with snare polypectomy, add		35.40	
E799	— each additional polyp, add — (to a maximum of 2 additional polyps)		17.70	
E701	— with laser coagulation, add		22.30	

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code	OESOPHAGUS - Cont'd	Asst.	Surg.	Anaes.
	Incision		\$	
	Oesophagostomy			
S084	Cervical — other than neonatal		127.50	
S085	— neonatal		194.90	
S086	Thoracic		194.90	
S082	Intrathoracic oesophagus tube			
S083	— via laparotomy		262.20	6
S081	— via oesophagoscope (includes Z519)		194.90	6
	Transoesophageal division of oesophageal varices including oesophageal anastomosis		425.20	
	Excision			
S087	Intrathoracic diverticulum		311.80	
S088	Crico pharyngeal diverticulum or crico pharyngeal myotomy		262.20	
S089	Partial oesophageal resection and reconstruction (including intestinal transposition)		662.50	17
S090	Total thoracic oesophageal resection		556.25	13
E730	with reconstruction, add		329.50	4
	Repair			
S161	Heller procedure		364.90	
S163	— with oesophageal hiatus hernia repair		506.60	
S100	Total thoracic oesophageal myotomy when sole procedure performed		460.60	
S101	— with oesophageal hiatus hernia repair		591.70	
S091	Oesophageal hiatus hernia — abdominal or transthoracic approach with fundal plication		340.10	
S092	— recurrent		435.80	
E744	— with gastroplasty, add (to S091 or S092)		70.90	
E742	— When S091 or S092 with or without gastroplasty is done in conjunction with cholecystectomy and/or vagotomy with or without drainage procedures, add E742 (to S091, S092, with or without E744) for each additional procedure(s) performed		131.10	
S095	Oesophageal stricture (Thal) — may include oesophageal hiatus hernia repair with or without gastroplasty		418.10	
S096	Ruptured oesophagus		311.80	
S097	Oesophago-gastrostomy		329.50	
S098	Oesophageal bypass, neck to abdomen		545.60	

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code		Asst.	Surg.	Anaes.
			\$	
	OESOPHAGUS - Cont'd			
	Suture			
S102	Closure of oesophago-tracheal fistula (includes oesophageal reconstruction and lengthening if necessary)		400.35	
	Dilation of Oesophagus (I.O.P.) (May not be claimed with Z519.)			
Z529	Passive (bougie) — initial session		26.60	
Z530	— repeat session (within three months following previous dilation)		13.50	
Z525	Pneumatic		70.90	
Z523	With rigid dilators guided over a string or wire		35.40	
Z531	Repeat dilations during the same admission		19.50	
	STOMACH			
	Endoscopies (I.O.P.)			
Z527	Gastroscopy (with or without biopsy or photography)		49.60	4
Z547	Gastroscopy with removal of foreign body		67.30	4
Z528	Subsequent (within three months following previous gastroscopy)		42.50	4
	Incision			
S116	Gastrotomy — with removal of tumour or foreign body	6	184.20	7
E731	— with suture of bleeding peptic ulcer, add		50.70	2
S117	Pyloromyotomy (Ramstedt's)	5	187.80	10
S118	Gastrotomy	6	148.80	7
E707	— when done with another intra-abdominal procedure		39.00	
	Excision			
Z526	Biopsy — (Incisional) by gastrotomy (I.O.P.)		46.05	
Z533	— by intubation (I.O.P.)		22.00	
	Gastrectomy			
S122	Wedge resection for ulcer	7	212.60	7
E708	with vagotomy, add		50.70	
E713	with previous partial gastrectomy, add		85.00	
S123	Partial or subtotal — distal	7	389.70	8
S125	— proximal	7	425.20	8
E731	with suture of bleeding peptic ulcer, add		50.70	2
E708	with vagotomy, add		50.70	
E709	with cholecystectomy, add		63.80	
E706	with choledochotomy, add		74.40	
E711	after previous gastro-enterostomy, add		63.80	
E712	After previous vagotomy, and pyloroplasty, add		63.80	
E713	After previous partial gastrectomy, add		85.00	

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code		Asst.	Surg.	Anaes.
	STOMACH - Cont'd		\$	
S128	Total gastrectomy, with or without splenectomy	7	584.60	9
S131	Vagotomy — truncal or selective	7	226.75	7
S124	— highly selective (as sole procedure without pyloroplasty or gastroenterostomy)	7	297.60	7
S121	Transabdominal vagotomy after previous vagotomy ...	7	255.10	8
S120	Gastric bypass or partition, for morbid obesity	7	382.60	10
	Repair			
S132	Pyloroplasty	7	212.60	7
S133	Pyloroplasty and vagotomy	7	322.40	7
E731	— with suture of bleeding peptic ulcer, add		50.70	2
S137	Pyloroplasty or gastroenterostomy plus vagotomy and cholecystectomy	7	471.20	8
E721	— with choledochotomy, add		74.40	1
S134	Gastroduodenostomy or gastrojejunostomy	7	212.60	7
E716	— either of above plus vagotomy add		106.30	
E711	— after previous gastroenterostomy, add		63.80	
E721	— with choledochotomy, add		74.40	1
	Suture			
S138	Closure of gastrostomy or other external fistula of stomach	5	180.70	6
S139	Gastrorrhaphy (for perforated ulcer or wound)	6	187.80	7
S140	Closure of gastrocolic fistula	7	354.30	7
	Introduction			
Z534	Gastric Cooling (I.O.P.) — ice water lavage of stomach .		17.70	
Z532	Gastric Cooling (I.O.P.) — oesophagogastric balloon, with alcohol coolant continuously recirculated		58.45	4
	INTESTINES (EXCEPT RECTUM)			
	Endoscopies (I.O.P.)			
Z560	Duodenoscopy (not allowed if Z399 performed on same patient within three months)		63.80	4
Z561	— with cannulation of pancreatic and/or common bile duct (see also code Z558, page 183)		141.70	4
Z749	Subsequent procedure (within three months following previous endoscopic procedure)		49.60	4

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

		Asst.	Surg.	Anaes.
Code	INTESTINES (EXCEPT RECTUM) - Cont'd		\$	
Z555	Endoscopy — of sigmoid to descending colon		37.20	4
E740	— to splenic flexure, add		37.20	
E741	— to hepatic flexure, add		18.40	
E747	— to caecum, add		18.40	
E717	— if biopsy and/or coagulation of angiodysplastic lesion(s) (one or more), add		16.30	
E749	— when Z555 rendered in private office, add		10.60	
Note:	for sigmoidoscopy with rigid scope, see page 185			
Z570	Fulguration of polyp through colonoscope (may be allowed in addition to colonoscopy)		28.30	4
E719	— each additional polyp, add — (maximum of 4 additional polyps)		14.20	
Z571	Excision of polyp through colonoscope (may be allowed in addition to colonoscopy)		88.60	4
E720	— each additional polyp, add — (maximum of 2 additional polyps)		44.30	
	Incision			
	Enterotomy			
S149	Ileostomy	6	226.75	7
S150	Small intestine — including excision of polypi or biopsy	6	226.75	7
S151	Insertion of feeding enterostomy	6	180.70	7
E737	— when done with another intra-abdominal procedure		46.05	
S154	Large intestine — including excision of polypi	6	226.75	7
S155	Colonoscopy with laparotomy	6	212.60	7
S156	Exteriorization of intestine (Mickulicz)	6	212.60	6
S157	Colostomy	6	226.75	6
S158	Caecostomy	6	170.10	6
S160	Entero-enterostomy	6	226.75	7
	Excision			
S162	Local excision of lesion of intestine	6	226.75	7
Z750	Resection of exteriorized intestine (I.O.P.)	6	46.05	6
	Resection with anastomosis			
	Small intestine			
S164	duodenum	6	336.60	7
S165	other	6	318.90	7
	Small and large intestine			
S166	terminal ileum, caecum and ascending colon	7	375.55	7
S167	Large intestine — any portion	7	375.55	7
E714	Repair of entero-cutaneous fistula in conjunction with bowel resection, add		42.50	
S168	Ileostomy, subtotal colectomy	7	513.70	7

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code		Asst.	Surg.	Anaes.
	INTESTINES (EXCEPT RECTUM) — Cont'd		\$	
S169	Total colectomy with ileo-rectal anastomosis			
S171	Left hemicolectomy with anterior resection or proctosigmoidectomy (anastomosis below peritoneal reflection and mobilization of splenic flexure)	9	602.30	9
S170	Ileostomy plus total colectomy plus abdomino-perineal resection	7	513.70	7
S173	2-Surgeon team — abdominal	9	708.60	10
S174	— perineal	9	602.30	10
S172	Total colectomy with mucosal proctectomy with ileal pouch, ileoanal anastomosis and loop ileostomy		177.15	
E738	— with continent ileostomy, add to S168, S169, S170, S173 or S174	9	1062.90	10
E718	Bowel resection following previous resection with anastomosis, or following S217, S213, S214 or S215, add		237.40	
Note:	E718 is not to be added to S218, S181, S182, S185.		88.60	
S188	Bowel resection without anastomosis (colostomy and mucous fistula)			
S189	Intestinal bypass for morbid obesity	6	333.00	6
		7	372.00	10
	Intestinal Obstruction — one stage (if staged procedure, refer to Surgical Preamble, paragraph (3)).			
S175	Without resection			
S176	With entero-enterostomy	6	283.40	6
S177	With resection	6	354.30	7
S180	With enterotomy	6	418.10	7
S178	Intestinal atresia (newborn)	6	318.90	7
S179	Meconium ileus	6	418.10	7
	Repair			
	Revision of ileostomy or colostomy			
S181	— skin level			
S182	— full thickness	5	67.30	5
S192	Simple revision of continent ileostomy pouch	6	212.60	6
S191	Complete reconstruction of continent ileostomy to include valve repair	6	212.60	6
S193	Revision of standard ileostomy into continent ileostomy pouch	6	584.60	7
S183	Caecopexy or sigmoidopexy when sole procedure performed	6	467.70	7
		5	141.70	6
	Suture			
S184	Suture of intestine			
E721	— with choledochotomy, add	6	191.30	6
			74.40	1

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

		Asst.	Surg. \$	Anaes.
Code	INTESTINES (EXCEPT RECTUM) - Cont'd			
	Closure of colostomy or enterostomy			
S185	— with or without resection and/or anastomosis	6	226.75	7
S187	Plication of small intestine for adhesions	6	322.40	7
Note:	For division or removal of adhesions only, use S312.			
	Manipulation (I.O.P.)			
Z538	Reduction of prolapse		15.60	4
Z539	Dilation of gastrostomy enterostomy, colostomy, etc. . .		15.60	4
Z540	Intubation of small intestine (therapeutic or diagnostic) with or without fluoroscopy		39.00	
E732	with biopsy, add		17.70	
	MECKEL'S DIVERTICULUM AND THE MESENTERY			
	Excision			
S194	Meckel's diverticulum	5	184.20	6
S195	Local excision of lesion	5	155.90	6
S199	Resection of mesentery	5	184.20	6
	APPENDIX			
	Incision			
S204	Drainage of abscess	5	145.30	6
	Excision			
S205	Appendectomy	5	155.90	6
S206	— with gross perforation and peritonitis	5	223.20	6
	RECTUM			
	Endoscopy (I.O.P.)			
Z535	Sigmoidoscopy (with rigid scope), with or without anoscopy		22.30	4
Z536	— with biopsy		26.90	4
Z592	— with decompression of volvulus		29.80	4
E746	When Z535, Z536 or Z592 rendered in private office, add		3.50	
	Incision			
	Proctotomy			
S210	— with exploration	4	63.80	4
S211	— with decompression (imperforate anus)	4	63.80	4
S212	— with drainage (perirectal abscess)	4	63.80	4
	Excision			
	Proctectomy			
S213	Anterior resection or proctosigmoidectomy (anastomosis below peritoneal reflection)	8	474.80	8

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code		Ast.	Surg.	Anaes.
	RECTUM - Cont'd		\$	
S214	Abdomino-perineal resection or pull through	8	574.00	10
	Two surgeon team			
S215	abdominal surgeon	8	474.80	10
S216	perineal surgeon		170.10	
S217	Hartmann procedure	8	389.70	9
S218	Colon reconstruction following Hartmann procedure (includes E718)	8	474.80	8
Z752	Biopsy of rectosigmoid for Hirschsprung's disease (I.O.P.)	3	50.70	4
E710	— each additional biopsy (to a maximum of three additional)		17.70	
S222	Presacral or trans-sacral proctotomy and excision of lesion	4	212.60	6
Z572	Electrocoagulation and/or excision of rectal carcinoma (I.O.P.)			
	— initial	3	88.60	4
Z573	— repeat within 30 days	3	50.70	4
	Polyps or tumours of rectum or sigmoid (max. — 2 polyps any size or technique) (I.O.P.)			
Z753	— electrocoagulation — base under 2 cm		14.90	4
Z754	— excision — base under 2 cm	3	50.70	4
Z755	— electrocoagulation or excision base over 2 cm	3	88.60	4
Note:	For fulguration or excision of tumours through the colonoscope use codes Z570, Z571.			
	Repair			
S223	Anastomosis of rectum	4	297.60	6
S224	Proctostomy	4	180.70	4
	Rectal prolapse			
S225	Excision of mucus membrane	3	145.30	4
S226	Perineal repair, major	4	226.75	4
S227	Abdominal approach	6	340.10	8
S228	Insertion of Thiersh wire	3	116.90	4
	Suture			
S229	Suture of rectum, trauma — external approach	4	145.30	4
	Closure of fistula			
S231	Recto vaginal (any repair)	4	212.60	6
S525	Recto vesical	5	269.30	6
	Manipulation (I.O.P.)			
Z541	Dilation, and/or disimpaction or removal of foreign body under general anesthetic (when sole procedure performed)		35.40	4

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

		Asst.	Surg.	Anaes.
Code	RECTUM - Cont'd		5	
Z756	Fecal disimpaction — no anaesthetic		23.40	
	OPERATIONS ON THE ANUS			
Note:	The benefits for excision, ligation, injection of haemorrhoids and treatment of intra or perianal condyloma accuminata include anoscopy.			
	Endoscopy			
Z543	Anoscopy (proctoscopy) (I.O.P.)		3.90	
	Incision			
Z544	Biopsy (I O.P.)		21.25	4
Z545	Thrombosed haemorrhoid(s) (I.O.P.)		15.60	4
S241	Sphincterotomy	3	53.10	4
S242	— with excision of fissure	3	102.70	4
	Excision			
S246	Excision of fissure	3	70.90	4
S247	Haemorrhoidectomy and/or sphincterotomy, with or without sigmoidoscopy or repair of fissure	3	141.70	4
Note:	Includes dilation/injection of anal sphincter and removal of anal polyp.			
Z565	Complete haemorrhoidectomy using cryotherapy and/or Barron ligation(s) including rectal dilation (I.O.P.) ..		58.45	4
Z546	Barron ligation(s) (I.O.P.) (not to exceed 6 in any one year)		17.00	
Z566	Barron ligation(s) plus cryotherapy (I.O.P.) (not to exceed 6 in any one year)		21.25	
S249	Local excision for malignancy	3	95.70	4
Z757	Excision of benign anal lesion(s) (I.O.P.)	3	24.80	4
S251	Fistula-in-ano	3	141.70	4
S252	Perineal pull through for imperforate anus	3	95.70	4
S253	Transplantation of ectopic anus	7	276.35	7
	Introduction (I.O.P.)			
Z575	Haemorrhoid injections (Maximum 6 in any one year) ..		17.00	
Z576	Injections for anal fissure		22.00	4
	Repair			
S256	Excision of scar, for stenosis	3	81.50	4
S257	Anoplasty, for stenosis	4	180.70	4
S258	Repair of anal sphincter	4	180.70	4
S259	Repair of anal sphincter and ano-rectal ring	4	219.70	4
	Destruction (I.O.P.)			
Z548	Cauterization of fissure		21.25	4

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code		Asst.	Surg.	Anaes.
	OPERATIONS ON THE ANUS - Cont'd		\$	
	Fulguration of condylomata			
Z549	— local anaesthetic		19.50	
Z758	— general anaesthetic	3	46.05	4
	Manipulation			
Z550	Dilation of anal sphincter (I.O.P.)		7.10	4
S248	Peter Lord procedure (includes sigmoidoscopy and dilation of anus)		31.90	4
	LIVER			
	Incision (I.O.P.)			
Z554	Biopsy, incisional		42.50	
Z551	Biopsy, needle		40.40	4
	Excision			
	Hepatectomy			
S269	Local excision of lesion	7	212.60	7
S275	Partial lobectomy	8	361.40	8
S270	Left lateral segmental excision (through falciform ligament)	12	556.25	12
S271	Extended right lobectomy (through falciform ligament)	12	807.80	12
S267	Complete left or right lobectomy	12	807.80	12
S272	Laparotomy, cholangiogram and biopsy (neonatal jaundice)	6	226.75	6
	Repair			
S273	Marsupialization and/or decompression of cyst(s) or abscess(es)	7	212.60	7
E715	— more than three cysts or abscesses, add		46.05	
	BILIARY TRACT			
Notes:	(1) When the common bile duct is examined during abdominal surgery, no additional benefit over and above the surgical benefit may be claimed for choledochoscopy or for cholangiogram.			
	(2) Biliary tract endoscopy includes examination of stomach and duodenum (i.e. Z558 or Z559 may not be claimed with Z560 or Z561).			
	(3) No claim should be made for cholecystectomy with hepatic lobectomy (S271, S267).			
Z558	Manipulation and/or removal of common bile duct stones with or without sphincterotomy (see also code Z561, page 181)		184.20	5

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

		Asst.	Surg.	Anaes.
Code	BILIARY TRACT - Cont'd		5	
Z559	Subsequent procedure (within three months following previous endoscopic procedure)		85.00	5
	Drainage			
S233	Percutaneous transhepatic catheter drainage of obstructed bile ducts, including daily supervision and including percutaneous cholangiogram and catheterization to duodenum if achieved		163.00	
S234	— replacement of catheter in above		31.90	
	Incision			
Z542	Intubation of bile duct for obstruction (I.O.P.)		42.50	
Z562	Biliary duct calculus manipulation and/or removal via T-tube tract (I.O.P.) — when sole procedure performed		70.90	7
S278	Cholecystostomy	7	230.30	7
S276	Choledochotomy	7	389.70	8
E704	— with choledochoscopy, add		17.70	
S280	Transduodenal sphincterotomy and choledochotomy ..	7	545.60	9
S281	Choledochoduodenostomy or choledochointerostomy or choledochocolicostomy	7	460.60	9
S282	Cholecystogastrostomy	7	276.35	7
S283	Cholecystoenterostomy	7	276.35	7
E743	— with enteroenterostomy, add (to S281, S283)		95.70	
S285	Intrahepatic choledochointerostomy (anastomosis above the common duct bifurcation)	12	566.90	12
	Excision			
S287	Cholecystectomy	7	283.40	7
E721	— with choledochotomy, add		74.40	1
E722	— with transduodenal sphincterotomy, add		102.70	1
E728	— with truncal or selective vagotomy, add		106.30	
E729	— with highly selective vagotomy, add		177.15	
S291	Choledochectomy for tumour	8	233.80	8
	(for reconstruction, refer to S281 or S285)			
	Repair			
S292	Common duct stricture dissection and/or resection	7	116.90	10
	(for reconstruction, refer to S281 or S285)			
S293	Biliary duct atresia, infant (see Preamble, Part B, paragraph 22)	8	I.C.	12
	PANCREAS			
Z762	Biopsy, needle (I.O.P.)		50.70	

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code	PANCREAS - Cont'd	Asst.	Surg.	Anaes.
		\$		
	Incision			
Z577	Biopsy, incisional (I.O.P.)		74.40	7
S297	Drainage of acute pancreatitis or abscess or marsupialization of cyst(s)	7	212.60	7
	Excision			
	Pancreatectomy			
S298	Complete with splenectomy	9	807.80	13
S309	Distal — body, tail and splenectomy with or without anastomosis	9	620.00	11
S300	"Whipple type" procedure	9	807.80	13
S301	Local complete excision of tumour or lesion	8	297.60	8
	Repair			
S305	Pancreatic cyst — gastrostomy	7	354.30	8
S306	— duodenostomy	8	354.30	8
S307	— jejunostomy	8	354.30	8
S304	Lateral pancreatoduodenostomy or anastomosis of filleted pancreatic duct to intestine (Puestow)	9	496.00	10
	ABDOMEN, PERITONEUM AND OMENTUM			
Notes:	(1) When the laparoscope is used as a means of entrance to perform an intra abdominal procedure, no extra benefit for laparoscopy may be claimed.			
	(2) When an exploratory laparotomy is performed followed by a colostomy through another incision in the abdomen, the colostomy should be claimed at 100% and the laparotomy at 85% of the listed benefit.			
	Paracentesis (I.O.P.)			
Z590	Aspiration for diagnostic sample		15.60	
Z591	Aspiration with therapeutic drainage with or without diagnostic sample		28.30	4
E724	Administration of chemotherapy, add		6.40	
Z763	Paracentesis with lavage for diagnosis (I.O.P.)		23.40	4
	Incision			
Z563	Needle biopsy of peritoneum (I.O.P.)		23.40	
Z564	Open lavage of peritoneal cavity for diagnosis without manual exploration of peritoneal cavity (I.O.P.)		46.05	4

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code	ABDOMEN, PERITONEUM AND OMENTUM — Cont'd	Asst.	Surg. \$	Anaes.
S312	Laparotomy, with or without biopsy (except biopsies of stomach, liver, pancreas and multiple para-aortic lymph nodes)	6	155.90	6
Note:	S312 — Use for division or removal of adhesions, if no other abdominal surgery performed. — may not be claimed with other intra-abdominal procedures (except for I.O.P.)			
E745	Insertion of tubes and post-operative continuous peritoneal lavage — when combined with any other abdominal procedure, add		58.45	
S321	Laparotomy for acute trauma	6	212.60	6
E733	with repair of intestine, single — add		88.60	3
E734	multiple or with resection, add		131.10	3
E735	with splenectomy, (partial or complete), add	2	177.15	3
E723	with repair of lacerated spleen, add	2	85.00	3
E736	with repair of lacerated liver, add	2	116.90	3
E739	with repair of diaphragm, add	2	74.40	2
	Peritoneal abscess			
S313	Subphrenic	7	226.75	7
S314	Abdominal	6	145.30	6
Z569	Pelvic abscess, incision drainage — rectal or vaginal approach (I.O.P.)		74.40	4
Z574	Removal of infected sutures from abdominal wall or re-exploration of wound for bleeding — general anaesthetic (I.O.P.)	4	58.45	4
S311	Umbilical vein intra-abdominal dissection and catheterization (for newborn see pg. 88)	6	141.70	6
S320	Insertion of antabuse into abdominal wall		35.40	
	Insertion of peritoneo-jugular shunt for ascites			
S203	— primary	7	177.15	7
S209	— revision	7	120.50	7
	Excision			
S316	Excision of full thickness abdominal wall tumour and primary closure (see Preamble, Part B, paragraph 22)		I.C.	6
S317	Umbilectomy — plastic	4	67.30	4
S318	Panniculectomy (requires O.H.I.P. authorization (see Surgical Preamble, paragraph (17))	6	262.20	6
E748	— with repair of umbilical hernia, add		63.80	
Note:	S318 includes any necessary diastasis repair.			

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code	ABDOMEN, PERITONEUM AND OMENTUM – Cont'd	Asst.	Surg.	Anaes.
			\$	
S319	Mesenteric cyst	6	201.95	6
	Endoscopy			
	Peritoneoscopy or laparoscopy (I.O.P.)			
Z552	— without biopsy	4	67.30	6
Z553	— with biopsy and/or lysis of adhesions and/or removal of foreign body	4	86.80	6
	Repair			
S325	Omentopexy, sole operative procedure	6	145.30	6
	Herniotomy			
	Inguinal or femoral — single			
S326	— infants and children, with or without hydrocoele repair	4	155.90	4
S324	— adolescents and adults	4	177.15	4
E727	Hydrocoele repair, add to S324, S329, S330 or S331 — not applicable to infants or children		39.00	
S328	Unilateral with exploration of other side, infants and children	4	201.95	4
	Strangulated or incarcerated			
S329	— without resection of bowel	4	233.80	4
S330	— with resection of bowel	6	418.10	7
S331	Inguinal and femoral same side	4	240.90	4
S332	Umbilical — Adolescent or adult	4	187.80	4
S333	— Child (operative)	4	141.70	4
	Omphalocele and gastroschisis			
S334	— one stage repair	7	226.75	7
	Multiple staged repair			
S335	(a) Gross method or Silon mesh	7	226.75	7
S336	(b) Second stage repair (completion of abdominal wall closure)	7	226.75	7
	Diaphragmatic/morgagni, other than oesophageal hernia			
S337	One stage procedure — trans-abdominal	7	311.80	9
S338	Trans-thoracic	9	311.80	13
S339	Second stage and abdominal closure	4	180.70	9
S340	Ventral — post-operative	6	226.75	6
S344	Massive incisional hernia	6	258.60	6
S345	Massive sliding inguinal hernia	6	212.60	6
E725	Recurrent — all types, excepting oesophageal, add	2	53.10	2
E726	Repeat recurrent inguinal hernia (more than 2 repairs), add to S324, S326, S329, S330 or S331	2	95.70	2
S342	Epigastric	4	145.30	4

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code		Asst.	Surg.	Anaes.
		\$		
	ABDOMEN, PERITONEUM AND OMENTUM -			
	Cont'd			
	Suture			
S343	Secondary closure for evisceration (when sole abdominal operative procedure)	6	170.10	6

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM OPERATIONS ON THE URINARY SYSTEM

Code	KIDNEY AND PERINEPHRIUM	Asst.	Surg.	Anaes.
			\$	
Notes:	(1) No additional claim should be made for nephroscopy when done at the time of pyelolithotomy or nephrolithotomy.			
	(2) In a routine surgical approach to the kidney and related procedures, no additional claim should be made for rib resection carried out for access purposes.			
	(3) When the kidney has been operated on more than one month previously, the fee for the second surgery (except for S414) may be increased by \$51.00 (E752)			
	Incision			
Z601	Renal biopsy(s), unilateral, needle (I.O.P.)		54.60	4
S401	Drainage of kidney abscess	7	194.90	7
S402	Drainage of perinephric abscess	7	127.50	7
S403	Exploration of renal and peri-renal tissues (with or without biopsy or unroofing of cyst)	7	212.60	7
Note:	Use S403 for open renal biopsy. May not be claimed in addition to nephrectomy.			
	Nephrotomy			
S404	— with drainage — nephrostomy — when sole operative procedure	7	212.60	7
S405	— with removal of calculus	7	283.40	7
Z600	— change of nephrostomy tube (I.O.P.)		21.25	
S406	Transection of aberrant renal vessels — sole operative procedure	7	226.75	7
S407	Pyelotomy — with drainage	7	226.75	7
S408	— with removal of calculus	7	262.20	7
S409	— with diversion of urine	7	276.35	7
	Excision			
S410	Calycectomy with diversion of urine	7	301.15	7
S411	Partial or hemi-nephrectomy	7	318.90	7
S423	Partial or hemi-nephrectomy with total ureterectomy	7	347.20	7

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM OPERATIONS ON THE URINARY SYSTEM

Code		Asst.	Surg.	Anaes.
		\$		
	KIDNEY AND PERINEPHRIUM - Cont'd			
	Nephrectomy			
S412	— ectopic kidney	7	276.35	7
S413	— lumbar	7	276.35	7
S414	— secondary	7	311.80	7
S415	— transperitoneal	7	311.80	7
S416	— thoraco-abdominal or radical nephrectomy	9	400.35	13
S417	— with gland dissection	9	418.10	13
S418	— with incision and repair of inferior vena cava for removal of tumour thrombus (see Preamble, Part B, paragraph 22)	I.C.	I.C.	I.C.
S419	Nephro-ureterectomy, total, without resection of uretero-vesical junction	7	311.80	10
S420	Nephro-ureterectomy, total, with resection of uretero- vesical junction	7	350.75	10
S421	Excision of stenosed renal artery with reimplanation or homograft	7	467.70	15
	Repair			
S422	Pyeloplasty (with or without nephropexy)	7	311.80	7
E754	— with removal of calculus, add		35.40	
S426	Nephropexy — when sole operative procedure	7	226.75	7
S428	Symphysiotomy, for horseshoe kidney with or without nephropexy and associated procedures	7	262.20	7
	Suture			
S429	Ruptured or lacerated kidney — repair or removal . . .	7	262.20	7
S430	Removal of staghorn calculus filling renal pelvis and calyces to include x-ray control	7	389.70	9
	Extra Renal Procedures			
S431	Excision of retroperitoneal tumour	7	226.75	7
S432	Exploration retroperitoneal tumour	7	155.90	7
S433	Sacro-coccygeal teratoma	6	262.20	6
	Renal Transplantation Procedures: (submit on recipient's claim) These benefits do not include immuno-suppressive therapy which is on a "fee for service" basis.			
S435	Kidney transplant (surgical team benefit)		708.60	13
S434	Kidney re-transplant (surgical team benefit)		850.30	13

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM OPERATIONS ON THE URINARY SYSTEM

		Asst.	Surg.	Anaes.
Code	KIDNEY AND PERINEPHRIUM – Cont'd		\$	
S436	Donor nephrectomy — surgical team benefit, unilateral or bilateral (to include renal perfusion with hypothermia)	7	276.35	8
E753	— live donor, add		77.90	
Note:	For nephrological components of the above, see Diagnostic and Therapeutic Procedures.			
S437	Renal autotransplantation		531.45	10
	URETER			
	Endoscopic Procedures			
S470	Cystoscopy with manipulation and/or removal of calculus and retrograde pyelogram if required		141.70	4
	Incision			
S442	Peri-ureteral abscess	6	127.50	6
	Ureterotomy, abdominal or vaginal exploratory or for drainage			
S443	— upper 2/3	6	155.90	6
S444	— lower 1/3	6	226.75	6
	with removal of calculus			
S445	— upper 2/3	6	223.20	6
S446	— lower 1/3	6	283.40	6
	where ureter has been previously opened			
S447	— upper 2/3	6	262.20	6
S448	— lower 1/3	6	311.80	6
	Excision			
S449	Ureterectomy — including uretero-vesical junction	6	262.20	7
S450	— other	6	194.90	7
	Repair			
S451	Uretero-vesical anastomosis or re-implantation			
	unilateral	6	262.20	8
S561	Re-implantation of ureter with extensive tapering	6	389.70	8
S562	Bifid ureter	6	283.40	8
S452	Uretero-ileal conduit	6	467.70	9
S453	Uretero-ileal conduit with total cystectomy	9	744.00	15
S454	Uretero-ileal conduit with ureterectomy and ileal replacement	6	531.45	7
	Uretero-intestinal anastomosis or transplant			
S455	— unilateral	6	194.90	6
S462	— bilateral	6	262.20	6
S456	— bilateral with cystectomy, one stage	9	584.60	13
S457	Uretero-ureterostomy	6	329.50	8

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM OPERATIONS ON THE URINARY SYSTEM

		Asst.	Surg. \$	Anaes.
Code	URETER — Cont'd			
S458	Ureterostomy — cutaneous — unilateral	6	155.90	6
S463	— with lower third ureterotomy	6	226.75	6
S459	Uretero-vaginal fistula	6	340.10	6
S460	Ureterolysis for peri-ureteral fibrosis unilateral	6	262.20	6
S461	Ureteroplasty (Hutch) — unilateral	6	194.90	6
S427	Bladder flap (Baori) — to include re-implantation of ureter	6	297.60	6
	Suture			
	Spontaneous or traumatic rupture or transection			
S465	— immediate — upper 2/3	6	226.75	6
S466	— lower 1/3	6	262.20	6
S467	— late repair — upper 2/3	6	262.20	6
S468	— lower 1/3	6	283.40	7
	BLADDER			
Note:	(1) No extra claim may be made for EUA when done at the time of cystoscopy.			
	(2) Visit benefits only, as applicable, may be claimed for changing a suprapubic tube.			
	(3) No additional claim should be made for suprapubic cystotomy when performed in the routine course of gynaecological surgery.			
	Endoscopy — Cystoscopy			
	Diagnostic Procedures (I.O.P.)			
Z606	Diagnostic with or without urethroscopy (Panendoscopy)		43.60	4
Z607	Repeat within 30 days		21.25	4
Z608	With catheterization of ureters with or without hydrodistension of the bladder, brush biopsy of bladder, collection of ureteral specimens, intravenous function test and retrograde injection of opaque media and calibration and/or dilatation of the ureter (e.g. split function, Howard's test or retrograde pyelogram)			
	— one or both sides		53.10	4
Z610	With transurethral biopsy, brush biopsy of renal pelvis and/or ureter and/or insertion of ureteral stent		59.50	4
Z612	With manometry (to include urethral pressure profile if required)		51.00	4
Z613	With meatotomy or internal urethrotomy		48.90	4
Z614	With meatotomy and retrograde pyelogram		59.50	4

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM OPERATIONS ON THE URINARY SYSTEM

Code		Asst.	Surg.	Anaes.
			\$	
Z615	BLADDER - Cont'd With needle biopsy of prostate		63.80	4
	Therapeutic Procedures			
S492	With electrocoagulation — tumour(s)		70.90	4
S493	— Hunner ulcer		70.90	4
	With excision of tumour or tumours including base and adjacent muscles and electrocoagulation if necessary			
S494	Single tumour 1 to 2 cm. diameter		163.00	4
S495	Single tumour over 2 cm. diameter		262.20	4
S496	Multiple tumours		262.20	4
S497	With resection bladder neck, female		102.70	4
S498	With resection bladder neck, male		194.90	5
S499	With electro surgical ureteral meatotomy		102.70	4
S500	With removal foreign body or calculus		102.70	4
S501	With removal of ureteric catheter		44.60	4
E751	With insertion of radioactive substance, in addition to associated procedures (Z606 to S500)		33.30	
S502	With secondary surgical evacuation of bladder clots and control of haemorrhage		50.70	4
Note:	Z606 to S502 — "with" means the listed benefit includes the cystoscopy.			
	Introduction (I.O.P.)			
	Catheterization: acute retention, change of retention catheter or instillation of medication			
Z602	— office		5.10	
Z603	— home		9.60	
Z611	— hospital		5.10	
U.V.C.	— change of suprapubic tube		visit fees	
	Incision			
Z605	Aspiration (I.O.P.)		7.40	
S478	Cystotomy or cystostomy (see Note (3) page 196)	5	127.50	5
S479	Cystotomy or cystostomy and electrocoagulation of tumour	5	194.90	5
S480	Cystotomy with trochar and cannula and insertion of tube		50.70	5
E750	— when done in conjunction with another procedure, add		15.60	
S481	Cystolithotomy — when sole operative procedure	5	155.90	5
S476	Cutaneous vesicostomy	5	262.20	5
S477	Reduction cystoplasty (bladder plication)	5	212.60	5

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM OPERATIONS ON THE URINARY SYSTEM

Code		Asst.	Surg. \$	Anaes.
	BLADDER - Cont'd			
	Excision			
	Cystectomy			
S482	Partial for tumour or diverticulum (single or multiple)	6	226.75	6
S483	— with re-implantation of ureter	6	329.50	7
S490	— with re-implantation of ureters	6	432.20	7
S484	Complete cystectomy, without transplant	6	389.70	10
S485	— with uretero-intestinal transplant	8	584.60	13
S453	— with uretero-ileal conduit	9	744.00	15
S471	Excision of urachal cyst or sinus with or without umbilical hernia repair	6	177.15	6
S487	Excision of urachus, repair of bladder and diversion of urine	6	177.15	6
S488	Extrophy-excision of bladder and repair of abdominal wall, inclusive of graft	6	127.50	6
S489	— above including bilateral ureterosigmoidostomy ..	6	389.70	6
S491	Plastic repair of extrophy using bladder and including skin flaps	6	389.70	6
	Repair			
S512	Repair of ruptured bladder	5	194.90	6
S513	Cystoplasty, using intestine	8	389.70	9
	Plastic repair of bladder neck			
S518	— child	5	194.90	5
S519	— adolescent or adult	5	262.20	5
S520	With diverticulectomy	5	329.50	7
	Destruction			
S521	Litholapaxy and removal of fragments		127.50	4
	Suture			
	Closure of fistula			
S522	External, suprapubic	4	155.90	4
S523	Vesico-vaginal — vaginal approach	4	265.70	6
S524	— transvesical approach — with or without omental flap	5	276.35	6
Note:	See also S734, S711 on page 207.			
S525	Vesico-rectal or vesico-sigmoid	5	269.30	6

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM OPERATIONS ON THE URINARY SYSTEM

Code	URETHRA	Asst.	Surge.	Anaes.
			\$	
Preamble				
(1) No charge should be made for pre-cystoscopy dilatation of the male urethra unless urethral stricture is the primary diagnosis. No charge should be made for dilation of the female urethra when done at the same time as cystoscopy.				
Endoscopy				
Z617	Urethroscopy — diagnostic (I.O.P.)		21.25	4
Z618	— with biopsy (I.O.P.)		46.05	4
S547	Removal of foreign body or calculus		102.70	4
Incision				
Z616	Biopsy of urethra (without endoscopy) (I.O.P.)		14.20	4
S530	Urethrotomy — external	3	127.50	4
S532	— transurethral (visual)	3	194.90	4
S531	Urethrostomy	3	127.50	4
Z604	Meatotomy and plastic repair (I.O.P.)		18.80	4
S533	For extravasation of urine with multiple drainage	3	127.50	4
S534	— above with external urethrotomy or cystotomy ..	3	194.90	4
Z609	Peri-urethral abscess (I.O.P.)		18.80	4
Excision				
S536	Caruncle	3	50.70	4
S537	Urethral papilloma, single or multiple		50.70	4
S541	Diverticulectomy — male or female	3	155.90	4
S542	Posterior urethral valve	4	155.90	4
S543	Prolapse urethra, excision	3	50.70	4
S544	Urethrectomy — radical	4	127.50	4
Repair				
S548	Urethral sling	4	226.75	4
S549	Retropubic urethropexy (e.g. Marshall Marchetti, Burch) for stress incontinence — primary procedure ..	4	184.20	5
S546	— repeat procedure for failed retropubic or vaginal surgery for stress incontinence	4	212.60	6
Note:	See also S731-S733, page 207.			
S559	Prosthetic procedure for urinary incontinence (e.g. Kauffman, Rosen type, etc.)	3	226.75	5
S560	— where perineum has been previously operated on for incontinence	3	262.20	5
S563	— removal of perineal incontinence prosthesis	3	85.00	4

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM OPERATIONS ON THE URINARY SYSTEM

Code		Asst.	Surg.	Anaes.
		\$		
	URETHRA - Cont'd			
	Urethroplasty			
	1st stage —			
S545	— posterior	4	226.75	6
S550	— anterior	4	170.10	4
S558	2nd stage —	4	138.20	4
S535	One stage repair (to include skin graft if necessary)	4	226.75	6
	Suture			
S551	Rupture, anterior urethra (diversion of urine extra) . . .	4	102.70	4
S552	Posterior urethra — immediate repair	4	262.20	4
S553	— late repair	4	329.50	5
	Fistula			
S554	Penile urethra (diversion of urine extra)		54.60	4
S555	Perineal urethra	4	194.90	4
S556	Recto-urethral with diversion, colostomy and closure of colostomy	6	329.50	7
	Destruction			
S557	Urethro-vesicolysis — when sole operative procedure . .	3	127.50	4
S564	Transurethral incision or resection of external sphincter (when sole operative procedure)		194.90	4
	Manipulation (I.O.P.)			
Note:	No claim should be made for pre-cystoscopy dilation of the male urethra unless urethral stricture is the primary diagnosis. No claim should be made for dilation of the female urethra when done at the same time as cystoscopy.			
	Dilation of stricture, male (Passage of Sounds)			
Z621	— local anaesthetic		6.40	
Z619	— general anaesthetic		31.20	4
Z622	Dilation of urethra, female		3.20	
Z620	— under general anaesthetic		24.80	4

SURGICAL PROCEDURES

OPERATIONS ON THE MALE GENITAL SYSTEM

Code	PENIS	Asst.	Surg.	Anaes.
		\$		
	Incision — Slit of prepuce (complete care)			
S567	Newborn		8.50	
S568	Infant		12.75	4
S569	Adult or child		17.70	4
	Excision			
S570	Circumcision — newborn (complete care)		21.25	
S571	— infant		31.20	4
S572	— adult or child	3	50.70	4
Z702	Biopsy (I.O.P.)		14.20	4
	Amputation			
S574	Partial	4	102.70	4
S575	Partial with inguinal glands 1 or 2 stages	4	262.20	5
S576	Radical with inguinal and femoral glands 1 or 2 stages	6	329.50	7
Z701	Condylomata (I.O.P.)			
	— local anaesthetic		19.50	
Z767	— general anaesthetic		46.05	4
S599	Excision plaque for Peyronies disease	4	124.00	4
	— where grafting is necessary, add appropriate skin graft benefit.			
	Repair			
S577	Epispadias	3	194.90	4
	Hypospadias			
S578	One stage repair	4	194.90	4
S579	Chordee repair	4	127.50	4
S580	Plastic reconstruction, urethra	4	194.90	4
S581	Closure urethro-cutaneous fistula		54.60	4
S597	Penile prosthesis for impotence	4	194.90	4
R827	Creation of A.V. fistula, (Saphena-Cavernosa shunt) . .	4	201.95	6
	TESTIS			
	Incision			
Z703	Abscess (I.O.P.)		33.30	4
Z704	Biopsy (I.O.P.) — single		33.30	4
Z705	— bilateral		49.60	4
Z706	— with vasography (see also page 79)		70.90	4
S589	Orchidectomy — unilateral	3	102.70	4
S590	Radical removal lymph nodes for testicular tumour . . .	6	329.50	8
S598	Radical orchidectomy for malignancy — unilateral . . .	3	138.20	4

SURGICAL PROCEDURES

OPERATIONS ON THE MALE GENITAL SYSTEM

Code		Asst.	Surg.	Anaes.
			\$	
	TESTIS - Cont'd			
	Repair			
S591	Orchidopexy, any type, one or two stages to include hernia repair where required	4	194.90	4
S592	— second stage (Torek) repair		33.30	4
S593	Exploration for undescended testicle, without orchidopexy	4	155.90	4
S594	Reduction of torsion of testis or appendix testis and repair	3	138.20	4
S595	Ruptured testicle	3	102.70	4
S596	Insertion of testicular prosthesis	3	102.70	4
	EPIDIDYMIS			
	Incision			
Z707	Abscess (I.O.P.)		33.30	4
	Excision			
S601	Spermatocoele or spermatic granuloma	3	102.70	4
S602	Epididymectomy — unilateral	3	102.70	4
	Repair			
S606	Anastomosis Epididymovasostomy — unilateral	3	102.70	4
	TUNICA VAGINALIS			
	Incision			
Z708	Hydrocoele aspiration (I.O.P.)		9.60	
	Excision			
S611	Hydrocoele — unilateral	4	102.70	4
Note:	When done with hernia repair use E727.			
	SCROTUM			
	Incision			
	Abscess or haematocoele (I.O.P.)			
Z709	— local anaesthetic		11.70	
Z768	— general anaesthetic		33.30	4
S616	— and exploration — unilateral	3	50.70	4
	Excision			
S618	Resection of scrotum	3	127.50	4
	Suture			
S619	Trauma — laceration — depending on extent and complications (see Preamble, Part B, paragraph 22)		I.C.	I.C.

SURGICAL PROCEDURES

OPERATIONS ON THE MALE GENITAL SYSTEM

Code	VAS DEFERENS	Asst.	Surg.	Anaes.
			\$	
	Incision			
Z710	Vasography (I.O.P.)		33.30	4
	Repair			
S624	Anastomosis, unilateral	3	127.50	4
S625	— including biopsy and vasography	3	155.90	4
	Suture			
S626	Ligation — uni or bilateral (vasectomy)	3	63.80	4
	SPERMATIC CORD			
	Excision			
S630	Hydrocoele — single	3	102.70	4
Note:	When done with hernia repair use E727.			
S631	Varicocele (abdominal or scrotal approach) — single ..	3	102.70	4
	SEMINAL VESICLES			
	Incision			
Z711	Abscess (I.O.P.)		70.90	4
	Excision			
S636	Vesiculectomy	3	329.50	4
	PROSTATE			
Note:	A T.U.R. followed within 10 days by a bilateral orchidectomy because of carcinoma of the prostate should be claimed in accordance with paragraph (3) of the Surgical Preamble.			
	Incision			
Z712	Biopsy, needle (I.O.P.)		46.05	4
Z713	— with drainage abscess (I.O.P.)	3	54.60	4
S644	Biopsy, perineal, open operation	3	127.50	4
	Removal of calculus (with or without biopsy)			
S642	— perineal	4	262.20	4
S643	— retropubic	4	262.20	4
	Excision			
	Prostatectomy (not to include investigative cystoscopy) but to include vasectomy when indicated.			
S645	Perineal	6	265.70	6
S646	Perineal with vesiculectomy	8	400.35	11

SURGICAL PROCEDURES

OPERATIONS ON THE MALE GENITAL SYSTEM

Code		Asst.	Surg.	Anaes.
		\$		
	PROSTATE - Cont'd			
	Suprapubic (with or without removal of bladder calculi)			
S647	— one stage	5	276.35	6
S648	— two stages — 1st stage	5	127.50	6
S649	— 2nd stage	5	155.90	6
	Retropubic (with or without removal of bladder calculi)			
S650	— simple	5	276.35	6
S651	— radical	5	425.20	6
S641	Transpubic total prostatovesiculectomy with pelvic lymph node dissection (includes laparotomy when necessary)	8	531.45	11
S652	Staging pelvic lymphadenectomy for prostatic cancer . .	7	194.90	7
	Endoscopy (cystoscopy included.)			
S655	Transurethral resection of prostate (no additional benefit for cystoscopy, meatotomy, dilatation of stricture, internal urethrotomy or vasectomy when done at the same time)		283.40	6
S654	Transurethral resection of prostate for residual or regrowth of tissue within one year of previous prostatectomy by same surgeon		187.80	6
S656	Transurethral drainage of abscess, complete care		50.70	5

SURGICAL PROCEDURES

VULVA AND INTROITUS

Preamble

- (1) In composite operations such as anterior and posterior repair and D. & C. or anterior and posterior repair and cauterization of cervix and biopsy, the benefit shall, unless otherwise mentioned below, be that of the major procedures.
- (2) If a D & C is part of the normal procedure carried out by the surgeon prior to other gynaecological surgery, no extra benefit should be claimed for the D & C. If the D & C is done because of disease or for therapeutic reasons prior to other gynaecological surgery, the D & C should be claimed at 85% of the listed benefit in keeping with paragraph (3) of the Surgical Preamble.
- (3) If culdoscopy is performed as part of a sterilization procedure, no extra claim should be made for the culdoscopy.

OPERATIONS ON THE FEMALE GENITAL SYSTEM

		Asst.	Surg.	Anaes.
	Incision		\$	
S700	Hymenotomy		35.40	4
	Abscess of vulva, Bartholin or Skene's gland (I.O.P.) — incision and drainage			
Z714	— local anaesthetic		11.70	
Z715	— general anaesthetic	3	31.90	4
Z716	Marsupialization of Bartholin's cyst or abscess (I.O.P.) (includes Z714 or Z715)	3	40.40	4
Z717	Perineotomy (I.O.P.)		11.70	
	Excision			
	Biopsy(s) — when sole procedure (I.O.P.)			
Z477	— local anaesthetic		13.10	
Z475	— general anaesthetic	3	30.10	4
S707	Hymenectomy (with or without perineotomy)		45.35	4
S706	Cyst of Bartholin's gland	3	88.60	4
	Condylomata — single or multiple (I.O.P.)			
Z733	Chemical — single		4.25	
Z734	— two		6.40	
Z735	— three or more		9.20	
	Surgical excision or electrodesiccation			
Z736	— local anaesthetic		19.50	
Z769	— general anaesthetic		46.05	4
Z737	Cryosurgery — initial or subsequent treatment		7.10	
	Vulvectomy			
S703	Simple — partial	4	155.90	4
S704	Radical — without gland dissection	6	251.55	6
E850	— with bilateral femoral node gland dissection with or without skin graft, add		134.60	1
E851	— with bilateral common iliac gland dissection with or without skin graft, add		187.80	2

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

		Asst.	Surg.	Anaes.
Code	VULVA AND INTROITUS - Cont'd		\$	
	Repair			
S708	Non obstetrical injury to vulva and/or vagina, and/or perineum (see Preamble, Part B, paragraph 22)		I.C.	I.C.
S705	Ligation — of varicose vein of labia		45.35	4
	VAGINA			
	Endoscopy			
Z478	Vaginoscopy (pre menarchal) with or without medication (I.O.P.)		19.50	4
	Incision			
S712	Culdotomy, drainage or needle puncture		45.35	4
S713	Culdotomy, incision and exploration	3	88.60	4
Z579	Culdoscopy (I.O.P.)		67.30	4
Z580	with biopsy		85.00	4
Z728	Incision and drainage of cyst, abscess or haematoma . .		31.90	4
U.V.C.	Vaginal insufflation		visit fees	
	Excision			
	Biopsy(s) — when sole procedure (I.O.P.)			
Z722	— local anaesthetic		13.10	
Z723	— general anaesthetic		31.90	4
S715	Excision of cyst(s), or benign tumour(s)	3	88.60	4
S742	Colpectomy — e.g., for carcinoma	4	251.55	6
S702	Excision of congenital vaginal septum	3	88.60	4
	Repair			
S716	Anterior or posterior repair	4	124.00	5
S717	Anterior and posterior repair	4	194.90	5
S718	Anterior, posterior repair and repair of enterocoele and/or vault prolapse	4	223.20	5
S719	Posterior repair and repair of enterocoele and/or vault prolapse	4	194.90	5
S723	Posterior repair and repair of anal sphincter	4	152.30	5
S720	Anterior repair (with or without posterior repair) and repair of uterine prolapse (Fothergill or Watkin's interposition)	4	230.30	5
S721	Anterior, posterior repair with excision of cervical stump	4	230.30	6
S722	Post hysterectomy vault prolapse and/or enterocoele, with or without anterior and posterior repair — vaginal or abdominal approach	4	230.30	6
S724	Perineorrhaphy	3	63.80	4
Note:	May not be claimed with delivery or with other vaginal surgery procedures.			

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

		Asst.	Surg. \$	Anaes.
Code	VAGINA - Cont'd			
S725	Colpocleisis (Le Fort or modification)	5	184.20	5
S726	Construction of artificial vagina (see Preamble, Part B, paragraph 22) (see also Appendix D)	4	I.C.	6
	Closure of fistula			
S523	Vesico-vaginal — single surgeon	4	265.70	6
S734	— two surgeons — vaginal surgeon	4	191.30	6
S711	— abdominal surgeon		191.30	
Note:	See also S524, page 198.			
S231	Recto-vaginal (any repair)	4	212.60	6
S729	Uretero-vaginal	6	336.60	6
S709	Urethro-vaginal	4	124.00	4
S730	Urethral caruncle or prolapse of mucosa		63.80	4
	Retropubic urethropexy for stress incontinence			
S549	— primary procedure	4	184.20	5
	— following previous failed procedure(s)			
S546	— repeat primary procedure	4	212.60	6
	— combined abdominal-vaginal procedure			
S731	— one surgeon	6	283.40	7
S748	— one surgeon following two or more failed procedures	6	407.40	7
S732	— two surgeons — vaginal surgeon	6	131.10	7
S733	— abdominal surgeon		223.20	
	— two surgeons following two or more failed procedures — vaginal surgeon	6	212.60	7
S749	— abdominal surgeon		269.30	
S751				
	Manipulation			
	Examination and/or dilatation — when sole procedure			
Z718	General anesthetic (I.O.P.)		30.10	4
Note:	Removal of I.U.D. under g.a.; use Z718.			
U.V.C.	Removal of I.U.D. without g.a.		visit fees	
	CERVIX UTERI			
	Endoscopy			
Z730	Colposcopy (screening) (I.O.P.)		5.85	
Z731	Initial investigation of abnormal cytology under colposcopic technique (to include biopsies and curetting) (I.O.P.)		22.70	
	Cauterization (I.O.P.)			
U.V.C.	Chemical		visit fees	
Z732	Cryotherapy		9.20	
Z724	Electrocautery		4.60	
Z725	Dilatation and cauterization under general anaesthesia .		30.10	4

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

		Asst.	Surg.	Anaes.
Code	CERVIX UTERI - Cont'd		\$	
	Conization			
S744	Knife conization with or without diagnostic curettage (residual stump)	3	106.30	4
Z729	Cryoconization, electroconization or CO ₂ laser therapy with or without curettage — for premalignant lesion (moderate or severe dysplasia or carcinoma in situ) previously proven by biopsy (I.O.P.)		24.80	4
	Excision			
Z720	Biopsy — with or without fulgurization (I.O.P.)		9.20	4
S765	Amputation of cervix	4	124.00	4
S766	Cervical stump — abdominal	6	163.00	6
S767	— vaginal	4	163.00	4
Note:	Excision of cervical polyp(s) under general anaesthesia, use Z720.			
U.V.C.	Cervical polyp without g.a.			visit fees
	Repair			
S774	Tracheloplasty for incompetent cervix	3	63.80	4
S750	Trachelorrhaphy (plastic repair of cervix) — not immediately following delivery	3	63.80	4
	CORPUS UTERI			
	Endoscopy (I.O.P.)			
Z583	Hysteroscopy with or without biopsy		35.40	
Z585	— with cannulization of tubes		56.70	
	Incision and Excision			
Z719	Endometrial biopsy — suction or curette — endometrial cytology — wash or brush (I.O.P.)		9.20	
Z581	Office endometrial curettage (I.O.P.)		22.70	
	Abortion-complete-under 20 weeks			visit fees
Z770	— incomplete — including D & C (I.O.P.)		42.50	4
S752	— therapeutic-D & C or intra amniotic injection		70.90	4
S756	— missed abortion		74.40	4
S770	— hysterotomy — abdominal or vaginal	6	166.50	6
S783	— hysterotomy — abdominal or vaginal, with tubal interruption	6	191.30	6
S754	Diagnostic curettage (with or without cauterization, biopsy of cervix, removal of polypi, Rubin's test or hysterosalpingography)		63.80	4

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

Code		Asst.	Surg.	Anaes.
			\$	
	CORPUS UTERI - Cont'd			
	Intracavitary application of radium or sealed sources including D.&C. carried out at same time as application (to include consultation fee)			
S753	— first application		113.40	4
S755	— repeat application (within 30 days)		56.70	4
S764	Myomectomy	6	184.20	6
	Hysterectomy (with or without adnexa)			
S757	Total — abdominal or vaginal	6	262.20	6
S758	— with anterior and posterior vaginal repair including enterocele and/or vault prolapse	6	354.30	6
S759	— with anterior or posterior vaginal repair including enterocele and/or vault prolapse	6	318.90	6
S710	— with omentectomy for malignancy	6	283.40	6
S760	Partial or subtotal	6	194.90	6
S761	— with anterior and posterior vaginal repair	6	255.10	6
S762	— with anterior or posterior vaginal repair	6	223.20	6
S768	— with total omentectomy	6	223.20	6
S769	Radical (Schauta) — vaginal (includes R912)	8	372.00	8
S763	Radical (Wertheim's) (includes R912)	8	407.40	8
	Repair			
S771	Hysteropexy (uterine suspension)	6	152.30	6
S772	— with anterior and posterior vaginal repair	6	223.20	6
S773	— with anterior or posterior vaginal repair	6	184.20	6
	Hysteroplasty			
S779	Excision of septum (Strassman)	6	194.90	6
S775	Unification of double uterus	4	251.55	4
S776	Uterine inversion, manual		85.00	4
S777	Uterine inversion, operative	4	194.90	6
S778	Presacral neurectomy (with or without ovarian neurectomy)	6	194.50	6
	FALLOPIAN TUBE			
	Excision, Suture or Repair			
S784	Ectopic pregnancy (surgical management)	6	191.30	6
S738	Salpingectomy and salpingo-oophorectomy (uni or bilateral)	6	191.30	6

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

Code		Asst.	Surg.	Anaes.
			\$	
	FALLOPIAN TUBE - Cont'd			
S741	Ligation, cauterization or removal of tubes by abdominal or vaginal approach, including laparoscopy, culdoscopy, or hysteroscopy — for tubal interruption (any method)	6	106.30	6
Note:	See also P033, page 110			
	Tubal plastic operation			
S735	Fimbriolysis — unilateral or bilateral	6	141.70	6
S736	Salpingostomy — unilateral or bilateral	6	194.90	6
S737	Hysterosalpingostomy (anastomosis of tubes to uterus)	6	255.10	6
S740	Resection of portion of tubes and re-anastomosis . . .	6	255.10	6
S739	Fimbriolysis and salpingostomy — unilateral or bilateral	6	248.00	6
S743	Repair of extensive tubal and peritubal disease for infertility using operating microscope — uni or bilateral	8	496.00	8
	OVARY			
	Excision (unilateral or bilateral)			
S780	Biopsy of ovaries by laparotomy	5	141.70	6
S781	Wedge resection of ovaries (e.g. Stein-Leventhal)	5	155.90	6
S745	Oophorectomy	6	194.90	6
S782	Oophorectomy with total omentectomy	6	223.20	6
S746	Oophorocystectomy	6	194.90	6
S747	Para ovarian cystectomy	6	194.90	6

SURGICAL PROCEDURES

OPERATIONS ON THE ENDOCRINE SYSTEM

Code	THYROID GLAND	Asst.	Surg.	Anaes.
		\$		
	Incision			
Z726	Aspiration, thyroid cyst (I.O.P.)		17.70	
Z727	Percutaneous silicone core needle biopsy, (I.O.P.)		35.40	6
Z771	Aspiration biopsy, thyroid gland or nodule fine needle method (I.O.P.)		17.70	
S786	Abscess, complete care		50.70	4
	Excision			
	Biopsy			
S787	Surgical	4	127.50	6
	Thyroidectomy			
S788	Total	6	375.55	8
S789	Subtotal	6	297.60	7
S790	Hemi	6	223.20	7
E880	— Parathyroid(s) identification and re-implantation, add		116.90	
S791	Excision of solitary nodule	6	184.20	6
	PARATHYROID, THYMUS AND ADRENAL GLANDS			
	Excision			
S795	Exploration and/or removal, parathyroids or parathyroid tumour	6	375.55	8
E880	— Parathyroid(s) identification and re-implantation, add		116.90	
S796	— if requiring splitting of sternum	10	403.90	13
S797	Thymectomy	10	379.10	13
	Adrenalectomy or exploration			
S798	— unilateral	10	276.35	10
S799	— bilateral, with or without oophorectomy	10	425.20	11
S800	Adrenalectomy — unilateral for Pheochromocytoma ...	10	361.40	13
Z772	Thymus transplant (I.O.P.)		50.70	4



SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code		Asst.	Surg. \$	Anaes.
N100	Hypothermia — when employed, basic units for any procedure on nervous system			25
BRAIN				
	Astrocytoma, oligodendroglioma, glioblastoma or metastatic tumour			
	Craniotomy plus excision			
N103	— supratentorial	11	669.60	15
N151	— infratentorial	11	761.70	15
N152	Craniotomy plus lobectomy	11	733.40	15
E901	— with operating microscope, add		141.70	
	Meningioma and other tumourous lesions			
	Craniotomy plus excision			
N102	— supratentorial	11	733.40	15
N153	— infratentorial or basal	11	903.50	15
E901	— with operating microscope, add		141.70	
E902	Lesion greater than 4 cm diameter, add to N102, N153		240.90	
E903	Team fee for acoustic neuroma, same approach . . . add		403.90	
	Intracranial aneurysm repair			
N105	Carotid circulation	11	814.90	15
N154	Vertebrobasilar circulation (including aneurysm of vein of Galen)	11	857.40	15
E901	— with operating microscope, add		141.70	
	Cerebral arteriovenous malformation			
	Craniotomy for obliteration and/or excision			
N106	— supratentorial	11	829.10	15
N155	— infratentorial	11	829.10	15
E901	— with operating microscope, add		141.70	
E908	Removal of intracerebral and/or subdural hematoma in conjunction with a ruptured intracranial aneurysm or arteriovenous malformation, add to N105, N106, N154, N155		141.70	
N107	Extracranial approach, including balloon catheter or embolization techniques	11	524.40	15
	Extracranial-intracranial microvascular anastomosis			
N218	Superficial temporal artery	11	698.00	15
N156	Occipital artery	11	768.80	15
E904	Posterior fossa		163.00	
E905	Use of graft (autogenous vessel or synthetic) add		124.00	
N121	Extracranial-intracranial long venous bypass (from internal carotid in the neck or any of the trunk vessels in the neck or chest to a major intracerebral vessel, i.e. vertebral, internal carotid, middle cerebral)	11	1417.20	15

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code		Asst.	Surg.	Anaes.
			\$	
	BRAIN - Cont'd			
	Carotid-cavernous fistula			
N108	Intracranial obliteration (to include combined cervical and intracranial procedure)	11	733.40	15
N118	Extracranial approach, including balloon catheter or embolization techniques	11	488.90	15
	Spontaneous intracerebral hemorrhage			
	Craniotomy plus removal			
N104	— supratentorial	11	574.00	15
N157	— infratentorial	11	659.00	15
N120	Burr hole plus drainage	11	315.30	15
	Intracranial cyst			
	Craniotomy plus evacuation (to include interventriculostomy)			
N158	— supratentorial	11	577.50	15
N159	— infratentorial	11	669.60	15
N160	Burr hole plus aspiration	11	265.75	15
	Brain abscess:			
N117	Craniotomy	11	669.60	15
N115	Burr hole and aspiration	7	329.50	7
Z818	Subsequent aspiration through existing burr hole within 30 days (I.O.P.)		141.70	
N113	Craniotomy for brain biopsy (other than for tumour) . .	11	389.70	11
N109	Hemispherectomy	11	878.70	15
N110	Lobectomy and/or excision of cortical scar for epilepsy .	11	963.70	15
N130	Craniotomy plus midline commissurotomy	11	676.70	15
N128	Repair of encephalocele	11	566.90	15
N129	Posterior fossa decompression for Arnold Chiari malformation	11	651.90	15
N123	Stereotaxis — intracranial (to include ventriculography)	11	517.30	11
N119	Intracranial implantation of chronic surface electrodes . .	11	478.30	11
Z823	Implantation, removal or revision of stimulation pack (I.O.P.)		99.20	
Z824	Removal of chronic surface or depth electrodes (I.O.P.)		177.15	
Z813	Burr hole plus needling of brain for biopsy (I.O.P) . . .	7	248.00	7
Z806	Ventriculogram (including burr holes, air or positive contrast) (I.O.P.)		85.00	
Z802	Ventricular puncture through previous burr hole or fontanelle, or puncture and/or aspiration of cisterna magna (I.O.P.)		46.05	7
Z825	Ventriculotomy (to include burr hole) (I.O.P.)		233.80	7
E916	With biopsy add		88.60	
E917	With interventriculostomy add		88.60	
E918	With removal of foreign body add		88.60	

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code		Asst.	Surg.	Anaes.
	BRAIN - Cont'd		5	
Z819	External ventricular drainage (I.O.P.)	5	113.40	5
Z820	Insertion of intracranial catheter or transducer for purposes of monitoring (I.O.P.)	5	170.10	5
Z812	Subsequent revisions or replacements within 30 days (I.O.P.) each	5	145.30	5
N127	Re-opening of craniotomy for post-operative haematoma or infection, or for removal of bone flap .	11	294.10	11
E919	Intracranial duraplasty (greater than 2 cm diameter), add to any intracranial procedure		173.60	
E920	Intraoperative electrophysiological monitoring and/or stimulation, add to any intracranial procedure		173.60	
E921	Repeat craniotomy (excluding N127, add to benefit for above surgery involving craniotomy)		131.10	
	Cranio-Cerebral Injuries			
U.V.C.	Non-operative care:		visit fees	
	Reduction of skull fracture:			
N139	Simple, depressed	7	226.75	7
N140	Compound	11	340.10	11
E912	— with repair of dural laceration, ... add		81.50	4
	Extracerebral haematoma and/or hygroma:			
N143	Drainage by burr hole(s) — unilateral	7	311.80	7
N144	Drainage and/or removal by craniotomy	11	488.90	11
	Cerebral Injury			
N148	Removal of intracerebral haematoma and/or debridement of traumatized brain (includes management of any skull fracture)	11	574.00	15
N149	Removal of foreign body from brain	11	574.00	15
N150	C.S.F. leak — intracranial repair (to include transsphenoidal approach)	11	630.65	15
N200	Decompressive craniectomy (frontal, sub-temporal) .	11	364.90	11
Z803	Subdural tap(s) (I.O.P.) — unilateral		31.90	
Z814	Diagnostic burr hole(s) (I.O.P.) — uni or bilateral	7	163.00	7
	SKULL			
	Repair of skull defect:			
N161	Acrylic or metal cranioplasty	11	368.50	11
N201	Rib graft cranioplasty (defect less than 7.5 cm.)	11	566.90	15
N202	Replacement of bone flap	11	311.80	11
N203	Skull tumour, excision	11	198.40	11

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code		Asst.	Surg.	Anaes.
		\$		
	SKULL - Cont'd			
	Craniosynostosis			
	Linear craniectomy:			
N206	one suture	11	269.30	11
N207	multiple sutures	11	382.60	15
	Morcellation procedure			
N162	one suture	11	290.50	11
N163	multiple sutures	11	460.60	15
	Lateral canthal advancement			
	Unilateral			
N164	— one surgeon	11	460.60	15
N165	— two surgeons — major portion of surgery	11	283.40	15
N166	— lesser portion of surgery		212.60	
	Bilateral			
N167	— one surgeon	11	602.30	15
N168	— two surgeons — major portion of surgery	11	372.00	15
N169	— lesser portion of surgery		265.70	
N208	Craniotomy for craniofacial repair	11	637.70	15
E922	With repair of frontonasal encephalocoele add		131.10	
	ORBIT			
N211	Craniotomy plus removal of orbital tumour	11	733.40	15
N212	Craniotomy plus orbital decompression (roof of orbit with or without lateral wall)	11	574.00	15
N213	Craniotomy for decompression of optic nerve(s)	11	733.40	15
E901	— with operating microscope, add to N211, N213 ...		141.70	
	PITUITARY			
N215	Hypophysectomy (other than for removal of tumour) — (any technique)	11	733.40	15
E901	— with operating microscope add		141.70	
	Excision of tumour			
N171	Transfrontal	11	804.30	15
E901	— with operating microscope add		141.70	
N172	Microscopic transphenoidal for macroadenoma	11	733.40	15
N173	Microscopic transphenoidal for microadenoma (less than 1 cm)	11	775.90	15
	CAROTID AND VERTEBRAL ARTERIES			
N220	Carotid endarterectomy (with or without bypass and/or patch graft)	7	460.60	10
N223	Vertebral endarterectomy	10	496.00	10
E923	Intraoperative cerebral blood flow determinations (with carotid endarterectomy, etc.), add to N220, Z808 ...		92.10	

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

		Asst.	Surg.	Anaes.
Code	CAROTID AND VERTEBRAL ARTERIES - Cont'd		5	
Z815	Temporal artery; biopsy, ligation or cryosurgery (I.O.P.)		60.20	4
Z808	Progressive carotid occlusion by Selverstone clamp (I.O.P.)	10	194.90	10
Z807	Removal of Selverstone clamp (I.O.P.)	10	177.15	10
CSF SHUNTING PROCEDURES				
N230	Shunting procedures, all types except those otherwise specified below	11	251.55	11
N209	Ventriculo-atrial shunt	11	290.50	11
N210	Lumbo-peritoneal shunt (including laminectomy)	11	251.55	11
	Revision of CSF shunt — operative			
N245	Proximal end	7	177.15	7
N175	Distal end (all shunts except ventriculoatrial)	7	177.15	7
N176	Distal end — ventriculoatrial	7	216.10	7
Z801	Revision — non-operative (I.O.P.)		42.50	
N174	Conversion of shunt (e.g. ventriculoperitoneal to ventriculoatrial) — includes removal of existing shunt	7	251.55	7
N246	Removal of shunt — any type	7	120.50	7
N247	Ventriculo-cisternostomy (Torkildsen)	11	354.30	11
Z809	Insertion of CSF reservoir (Ommaya) including burr holes (I.O.P.)	11	141.70	11
N249	Third ventriculostomy	11	368.50	11
Z821	Injection of diagnostic or therapeutic agent into shunt apparatus (I.O.P.)		31.90	
CRANIAL NERVES				
N258	Percutaneous coagulation of gasserian (trigeminal) ganglion or root — unilateral	11	223.20	11
N259	V — Decompression or rhizotomy (partial or complete) trigeminal nerve	11	287.00	11
N265	VII — Differential section facial nerve for hemi-facial spasm (extra-cranial approach)	6	240.90	6
N266	Anastomosis hypoglossal or accessory to facial nerve	6	357.80	6
E901	with operating microscope add to N266, N267		141.70	
N267	Occipital and/or suboccipital craniectomy for compression, decompression or section of cranial nerves	11	552.70	11
N269	XI — Division of nerves to sternomastoid in neck	6	152.30	6
Z826	Inferior dental neurectomy (I.O.P.)	3	124.00	4
Z827	Infraorbital or supraorbital neurectomy (I.O.P.)	3	113.40	4

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code	PERIPHERAL NERVES	Asst.	Surg.	Anaes.
			\$	
	Brachial plexus exploration:			
N280	In posterior triangle	6	248.00	6
N281	In axilla	6	279.90	6
N282	In posterior triangle and axilla	6	389.70	6
N283	Decompression by scalenotomy	6	106.30	6
N284	Decompression be excision of first rib — complete	6	265.70	6
E603	— with cervical rib, add		53.10	
	Exploration and/or decompression of sciatic nerve			
N177	Subgluteal	6	233.80	6
N178	In thigh	6	163.00	6
N179	Subgluteal and in thigh	6	255.10	6
N290	Decompression median nerve at wrist (carpal tunnel syndrome)	3	88.60	4
N293	Decompression lateral femoral cutaneous nerve	4	88.60	4
N285	Exploration and/or decompression and/or transposition and/or neurolysis of major nerve (excluding sciatic and carpal tunnel)	4	109.80	4
N286	Removal of tumour major peripheral nerve	4	212.60	4
	Suture of major peripheral nerve			
N287	Epineural	4	233.80	4
N180	Fascicular	4	283.40	4
N183	Graft of minor nerve e.g. digital	3	81.50	4
	Graft of major peripheral nerve, with or without lengthening procedure			
N288	Epineural	4	400.35	4
N181	Fascicular (regardless of the number of strands per gap)	4	428.70	4
E925	Delayed repair (more than 4 weeks)		85.00	
N289	Suture or decompression of small peripheral nerve (digital)	3	81.50	4
E911	— each additional		69.30	
E906	— with operating microscope, — add to peripheral nerve repair as specified (N285, N286, N287, N180, N288, N181, N289)		70.90	
E931	Repeat surgery on peripheral nerve (more than four weeks after original surgery), add		106.30	
N294	Division, obturator nerves	6	102.70	6
Z828	Biopsy and/or avulsion peripheral nerve I.O.P.	3	81.50	4
N295	Morton's Neuroma, excision	4	53.15	4
Z811	Excision of glomus tumour (I.O.P.)		39.00	4
Z136	Excision of neuroma — single, subcutaneous (I.O.P.) ..		39.00	4
N296	Denervation of gastrocnemius	4	95.70	4

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code		Asst.	Surg. \$	Anaes.
PERIPHERAL NERVES - Cont'd				
Z816	Implantation of electrode for peripheral nerve stimulation (I.O.P.)	3	92.10	4
AUTONOMIC NERVOUS SYSTEM				
	Sympathectomy: — unilateral			
N300	Cervical	6	223.20	6
N301	Cervicodorsal	10	318.90	10
N303	— thoracic approach	9	244.50	13
N304	Lumbar	6	184.20	6
SPINAL CORD AND NERVE ROOTS				
Note:	For operations on the spinal cord and nerve roots, the basic assistants' and anaesthetists' fees will depend on the surgical approach except if a basic fee is listed.			
N315	Cervical or thoracic	8		10
N316	Lumbar	7		8
Tumours: (claim must state location)				
N317	Extradural partial or total removal		517.30	
Removal by anterior or anterolateral cervical or thoracic approach				
N314	— one surgeon		733.40	
M137	— two surgeons — thoracotomy		240.90	
N313	— excision		648.40	
N318	Intradural (extramedullary) partial or total removal		690.90	
E914	— three segments or more, add		85.00	
Intramedullary:				
N319	— Biopsy and/or decompression		602.30	9
N320	— Removal		797.20	12
E914	— three segments or more, add		85.00	
E901	— with operating microscope (applies to intradural or intramedullary tumours)		141.70	
A.V. malformation of cord				
N321	Excision or operative obliteration; with or without evacuation of haematoma		797.20	12
E914	Three segments or more		85.00	
E901	— with operating microscope		141.70	
Z800	Myeloscopy (I.O.P.)		134.60	

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code		Asst.	Surg.	Anaes.
	SPINAL CORD AND NERVE ROOTS - Cont'd		\$	
	Decompressive Procedures:			
	Applicable to all operative procedures for decompression of the spinal cord and/or nerve roots, whether traumatic or non-traumatic, with the exception of tumours and arterio-venous malformations.			
	Cervical			
R451	— hemilaminectomy for disc disease with or without nerve root decompression (soft disc, osteophyte) .	6	382.60	10
E907	— with opening of dura, add		106.30	
E565	— with multiple levels, add per additional level . .		44.60	
E566	— bilateral, add		44.60	
	— spinal cord decompression (vertebral body, disc, trauma) — uni or bilateral			
N182	— anterior — one level		403.90	
E928	— each additional level, add		177.15	
E929	— interbody fusion (by same surgeon), per level, add		42.50	
N185	— posterior — one or two levels		403.90	
	Thoracic (congenital or traumatic deformity) — uni or bilateral			
	— anterolateral or posterolateral approach			
N186	— one surgeon		733.40	13
M137	— two surgeons — thoracotomy		240.90	13
N187	— decompressive procedure		648.50	
N188	— posterior approach — one or two levels		403.90	
	Lumbar			
R457	— hemilaminectomy for disc disease with or without nerve root decompression (soft disc, osteophyte) .	6	255.10	8
E907	— with opening of dura, add		106.30	
E565	— with multiple levels, add per additional level . .		44.60	
E566	— bilateral, add		44.60	
	— spinal cord and/or cauda equina decompression (spinal stenosis, bony abnormality) — uni or bilateral			
	— anterolateral or posterolateral approach			
N189	— one surgeon		591.70	
S312	— two surgeons — laparotomy		155.90	
N190	— decompressive procedure		488.90	
N191	— posterior approach — one or two levels (excludes lumbar hemilaminectomy for posterolateral intervertebral disc protrusion) . .		403.90	

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code		Asst.	Surg.	Anaes.
			\$	
E914	SPINAL CORD AND NERVE ROOTS - Cont'd			
	Posterior decompressive procedure extending 3 segments or more (applies to cervical, thoracic, lumbar), add			
E930	Open reduction of fractured spine (applies to any level), add		85.00	
E548	— with instrumentation, add		63.80	
Z236	Insertion of skull calipers (I.O.P.)		63.80	
			42.50	
	Laminectomy (uni or bilateral):			
N336	Laminectomy for intradural neurolisis or unusual lesions (e.g. diastematomyelia, tethered conus, intramedullary haematoma, etc.) — uni or bilateral		492.50	
E914	Laminectomy extending over 3 segments or more		85.00	
E901	— with operating microscope		141.70	
	Re-opening of laminectomy (within 6 months)			
N323	— for postoperative haematoma or infection		251.55	
N192	— for repair of C.S.F. leak		354.30	
N337	Repeat laminectomy or re-opening of laminectomy (at least 6 months after original procedure) for re-exploration of nerve root(s) with or without discectomy and/or foraminotomy — uni or bilateral			
E907	Opening of dura (associated with any decompressive procedure), with or without dentate ligament section	8	414.50	10
E926	Spinal duraplasty (applies to any spinal procedure)		106.30	
E927	Spinal cord irrigation for trauma (including opening of dura), add to N185, N188, N191		170.10	
			219.70	
	Fusion:			
	Fusion by same surgeon (applicable to any of the above procedures except anterior cervical interbody fusion (N182))			
E567	— one level		165.80	
E568	— two or more levels		216.80	
	Fusion by different surgeon			
R493	— one level		210.10	
R494	— two or more levels		245.10	
E574	Re-fusion of any of above		155.90	
E548	— with instrumentation		63.80	
	Syringomyelia:			
N193	Posterior fossa craniectomy and plugging of obex (to include decompression of Arnold Chiari malformation if present)		666.10	15

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code		Asst.	Surg.	Anaes.
			\$	
	SPINAL CORD AND NERVE ROOTS - Cont'd			
E919	Intracranial duraplasty (greater than 2 cm. diameter), add to any intracranial procedure		173.60	
N194	Syringo subarachnoid shunt		524.40	
N195	Terminal ventriculostomy		524.40	
N196	Syringopleural shunt		616.50	
E901	— with operating microscope (add to N193 to N196) ..		141.70	
	Ablative and Stimulation Procedures:			
N329	Percutaneous cordotomy or tractotomy		251.55	
N330	Open myelotomy for lesion (e.g. Tractotomy, midline commissurotomy, Bischoff's longitudinal myelotomy, etc.) — uni or bilateral		531.45	
N341	Medullary spinal trigeminal tractotomy		602.30	
E901	— with operating microscope, add		141.70	
N324	Implantation of spinal cord stimulator by laminectomy ..		372.00	
N326	Implantation of percutaneous electrodes and diagnostic stimulation of spinal cord (to include removal if case does not proceed to chronic stimulation)		201.95	
Z822	Implantation or revision of stimulator pack for chronic stimulation (I.O.P.)		127.50	
N332	Removal of stimulation system — not applicable if a new system is inserted		127.50	
Note:	N324, N326, Z822, N332 for "multiple sclerosis" are not a benefit of O.H.I.P. except for relief of intractable pain.			
N331	Spinal intradural anterior and/or posterior rhizotomy, uni or bilateral, any number of roots		414.50	
N333	Dorsal root entry zone lesions for pain relief (any number of levels) — includes use of operating microscope		662.50	
	Percutaneous vertebral facet denervation or intercostal neurectomy (I.O.P.)			
Z810	— first level		60.20	4
E909	— additional levels (to a maximum of 4 additional levels) — each		19.50	
	Percutaneous radiofrequency posterior rhizotomy — for pain or spasticity			
N340	— one or two roots		159.40	
E910	— third to sixth root, each		24.80	
Z817	Lumbar subarachnoid drainage of C.S.F. — (chronic), (I.O.P.)		46.05	
	Meningocele and Meningomyelocele			
N334	Repair of meningocele		276.35	

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code		Asst.	Surg.	Anaes.
			\$	
	SPINAL CORD AND NERVE ROOTS - Cont'd			
	Repair of meningocele			
N335	— one surgeon		368.50	
	— two surgeons			
N338	— neurosurgeon		233.80	
N339	— reconstructive surgeon		177.15	
N197	Repair of lipomeningocoele (to include release of tethered spinal cord)		503.10	
E901	— with operating microscope, add (to N197, N335 or N338)		141.70	
N198	Repair of anterior sacral meningocoele posterior approach (to include release of tethered spinal cord) .		574.00	
N199	Repair of intraspinal meningocoele (extradural cyst) ...		488.90	



SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES

Code	OPERATIONS ON THE EYE	Asst.	Surg.	Anaes.
		\$		
Z850	Examination and unlisted minor procedures under general anaesthesia (I.O.P.)		35.40	4
	EYEBALL			
	Excision			
E102	Enucleation	4	177.15	4
E103	Evisceration	4	177.15	4
E108	Enucleation, donor eye, post-mortem (one or both)		53.10	
	Repair			
E104	Removal of intraocular foreign body	4	248.00	6
E105	Non-magnetic — posterior segment	4	283.40	6
	Penetrating wound			
E106	with prolapse of intraocular tissue	4	177.15	6
E107	without prolapse of intraocular tissue	4	141.70	6
	CORNEA			
	Incision			
Z851	Paracentesis (I.O.P.)		35.40	4
	Removal embedded foreign body (I.O.P.)			
	local anaesthetic			
Z847	— one foreign body		17.70	
Z848	— two or more foreign bodies (see Preamble, Part B, paragraph 22)		I.C.	
Z852	general anaesthetic		35.40	4
U.V.C.	Corneal scraping		visit fees	
	Chelation of band keratopathy with EDTA (I.O.P.)			
Z849	local anaesthetic		17.70	
Z863	general anaesthetic		35.40	4
	Excision			
E206	Pterygium — simple (unilateral)		63.80	4
E205	— with partial keratectomy	4	159.40	4
E207	— with lamellar graft	4	283.40	8
E117	Keratectomy	4	159.40	4
E118	Excision of dermoid		88.60	4
	Cauterization of ulcer (I.O.P.)			
Z871	local anaesthetic		17.70	
Z853	general anaesthetic		35.40	4
	Replacement			
	Corneal transplant			
E121	penetrating	4	372.00	8
E951	with artificial prosthesis, add		35.40	
E122	lamellar	4	283.40	8

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES

		Asst.	Surg. \$	Anaes.
Code	CORNEA - Cont'd			
E123	Division of iris to cornea		106.30	4
	SCLERA			
	Incision			
E127	Sclerotomy, posterior		88.60	4
E128	Anterior chamber — open evacuation of clot	4	177.15	6
	IRIS AND CILIARY BODY			
E131	Peripheral iridectomy (laser)	4	163.00	4
E130	Optical iridectomy (surgical)	4	191.30	4
E132	Intraocular glaucoma procedures	4	191.30	6
Note:	Includes iridectomy, iridencleisis, corneoscleral trephine, cyclodialysis, sclerectomy or goniotomy.			
E133	Extraocular glaucoma procedures	4	124.00	4
Note:	Includes cyclodiathermy, cyclocryopexy.			
	CRYSTALLINE LENS			
	Incision			
	Needling (discission)			
E137	— primary or subsequent		109.80	5
E139	Capsulotomy	4	109.80	4
	Excision			
	Cataract (includes iridectomy and retrobulbar injection when administered by surgeon.)			
E140	— all types of by any procedure	4	283.40	8
E141	— extraction of dislocated lens	4	318.90	6
E950	— insertion of intraocular lens, extra		70.90	
E143	— excision of secondary membrane with corneal section following cataract extraction	4	177.15	6
E144	Removal of intraocular lens	4	177.15	6
E145	Repositioning of dislocated intraocular lens		88.60	4
E146	Insertion of secondary intraocular lens	4	194.90	8
E138	Repair of intraocular lens (McCannell suture procedure)	4	191.30	6
	VITREOUS			
E147	Vitreous transplant, implant or anterior vitrectomy	4	177.15	6
E148	Vitrectomy by infusion suction cutter technique (e.g. Peyman)	4	407.40	8
E149	Vitreous aspiration, posterior with needle for culture and/or injection of medication, with or without cryopexy	4	124.00	5

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES

Code	RETINA	Asst.	Surg.	Anaes.
E151	Re-attachment of retina and choroid by diathermy, photocoagulation or cryopexy as an initial procedure .		5	
E152	Scleral resection or buckling procedure — as a first operation with or without diathermy, photocoagulation or cryopexy	6	201.95	6
E156	Secondary operation following fresh detachment for new retinal hole(s) or tear(s) or traction band following initial procedure with or without diathermy, photocoagulation or cryopexy	6	325.95	6
E157	Secondary operation following unsuccessful detachment operation during same hospital stay with or without diathermy, photocoagulation or cryopexy	6	325.95	6
E153	Secondary operation following unsuccessful operation or fresh detachment in the same eye by a different surgeon with or without diathermy, photocoagulation or cryopexy	6	212.60	6
E161	Removal of scleral implant	6	425.20	6
E154	Photocoagulation (xenon, argon laser, etc.) — one eye .		56.70	4
E155	Cryopexy — extra-ocular or sub-conjunctival — one eye		92.10	6
			92.10	6
EXTRAOCULAR MUSCLES				
Repair				
Strabismus procedures				
E159	— one or two muscles, one or both eyes	3	177.15	5
E162	— three or more muscles, one or both eyes	3	212.60	5
E952	Repeat strabismus procedure (more than two previous repairs) by different surgeon, add		35.40	
ORBIT				
Incision				
E164	Drainage of abscess		141.70	6
E165	Lateral orbitotomy, e.g. Kronlein type	3	283.40	6
Excision				
Tumour or foreign body				
E166	— anterior route	4	177.15	6
E167	— posterior exposure	4	318.90	6
E171	Exenteration, with or without major plastic repair	4	248.00	6
E172	Biopsy (anterior route)		70.90	4

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES

Code		Asst.	Surg.	Anaes.
		\$		
	ORBIT — Cont'd			
	Repair			
	Orbital fracture, open reduction rim wall fracture			
E173	— zygomatic fracture dislocation	4	159.40	6
E174	— blowout fracture of floor	4	194.90	6
E175	Secondary repair of blowout fracture by combined or orbital approach	4	276.35	6
	EYELIDS			
	Incision			
	Drainage of abscess (I.O.P.)			
Z854	local anaesthetic		17.70	
Z855	general anaesthetic		35.40	4
	Excision			
	Chalazion — single or multiple (I.O.P.)			
Z874	local anaesthetic		17.70	
Z856	general anaesthetic		35.40	4
Z857	Epilation by hyfrecator, electrolysis or cryopexy (I.O.P.)		17.70	4
	Verruca, papilloma, keratosis, etc. — see pages 115 & 116			
	Unlisted Plastic Procedures			
E177	Very Minor (e.g. skin only)		60.20	4
E186	Minor (e.g. muscle repair)	3	92.10	4
E187	Intermediate (e.g. full thickness wedge resection)	4	170.10	4
E188	Major (e.g. translation of lateral flap)	4	255.10	5
E189	Extensive major (e.g. pedicle flap)	4	372.00	6
Note:	Descriptive details of procedure (eg: operative report) should be submitted with claims for codes E177, E186-E189 — Refer to Surgical Preamble, paragraphs (16), (17).			
	Suture			
E190	Tarsorrhaphy		70.90	4
E191	Double adhesion		106.30	4
	Repair			
E192	Ptosis	4	212.60	4
E193	repeat or second repair	4	265.70	6
E194	Distichiasis — unilateral	4	159.40	4
E195	Trichiasis, surgical repair by tarsal transplantation	4	159.40	4
E196	Entropion, other than Zeigler puncture	4	177.15	4

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES

Code		Asst.	Surg.	Anaes.
EYELIDS - Cont'd				
E197	Ectropion, other than Zeigler puncture		\$	
Z860	Zeigler punctures (for correction entropion/ectropion) (I.O.P.)	4	177.15	4
E199	Laceration, full thickness, including margin (see Preamble, Part B, paragraph 22)		17.70	4
E200	Blepharoplasty (O.H.I.P. authorization necessary.)		88.60-177.15	4
E201	Simple excision of skin of one lid		56.70	4
E202	Simple excision and repair of orbital septum — one lid ..	4	109.80	4
E211	Simple excision and repair of orbital septum and lid fold reconstruction — one lid	4	177.15	4
E953	Lid lengthening procedure	4	74.40	4
	— with scleral graft, add		53.10	
CONJUNCTIVA				
U.V.C.	Removal of foreign body		visit fees	
Excision				
E208	Peritomy (Gunderson conjunctival flap)		53.10	4
Z861	Biopsy (I.O.P.)		10.60	4
Repair				
E210	Plastic repair — depending on extent (see Preamble, Part B, paragraph 22)		I.C.	4
LACRIMAL TRACT				
Incision (I.O.P.)				
Z862	Dacryocystotomy — general anaesthetic		35.40	4
Z917	Three "Snip" punctum procedure		17.70	4
Excision				
E215	Dacryocystectomy	4	177.15	4
Repair				
Lacerated canaliculus				
E216	immediate repair	4	141.70	4
E217	delayed repair	4	212.60	5
E218	Dacryocystorhinostomy	5	283.40	5
E954	— with lacrimal bypass procedure (e.g. Lester Jones or canalicular reconstruction), add		53.10	
E219	Lacrimal bypass procedure (eg: Lester Jones) — when sole procedure (both stages)		124.00	4

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES

Code		Asst.	Surg.	Anaes.
	LACRIMAL TRACT — Cont'd		\$	
	Manipulation (I.O.P.)			
Z901	Irrigation of nasolacrimal system — unilateral or bilateral		5.50	
	Probing and dilation of duct			
	Local anaesthetic			
Z902	Initial or repeat, unilateral		7.80	
	General anaesthetic			
Z864	Initial or repeat — unilateral or bilateral		35.40	4
Z865	Initial or repeat, unilateral or bilateral with insertion of intyng tube or filament		46.05	4

OPERATIONS ON THE EAR

EXTERNAL EAR

	Endoscopy			
U.V.C.	Removal of foreign body — simple		visit fees	
Z866	— complicated — general anaesthetic (I.O.P.)		28.30	4
E302	— post auricular approach		141.70	4
E303	— from middle ear space		141.70	4
Z906	Removal of drainage tube(s) — general anaesthetic (I.O.P.)		24.80	4
Note:	Z906 may not be claimed with Z914.			
Z907	Debridement of ear(s) and/or repair of small perforation under microscopy (I.O.P.)		16.30	
Note:	When debridement of ears under microscopy is carried out for removal of cerumen or for access purposes only, no charge should be made for the debridement. If debridement of ears under microscopy is carried out because of pathology, a claim may be made for this service.			
Z908	— under general anaesthetic (I.O.P.)		28.30	4
	Incision			
Z909	Biopsy ear canal (I.O.P.)			
	— local anaesthetic		16.30	
Z846	— general anaesthetic (if sole procedure performed)		28.30	4
E305	Limited incision for perichondritis, removal of cartilage and drainage		92.10	4
E306	Radical surgery for perichondritis		187.80	5
	Excision			
Z904	Local excision, polyp — office (I.O.P.)		17.70	
Z905	— hospital (I.O.P.)		28.30	4

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES

		Asst.	Surg.	Anaes.
Code	EXTERNAL EAR - Cont'd		\$	
E300	Amputation — partial		92.10	4
E301	— complete		120.50	4
E311	Exostosis, simple endomeatal surgery and removal and drilling out of exostosis		92.10	4
E312	— with multiple removal with necessary grafting		141.70	4
E313	— post auricular approach		194.90	5
Z903	Pre-auricular sinus (I.O.P.)		21.25	4
E309	— complex (see Preamble, Part B, paragraph 22)		I.C.	5
Repair				
Congenital defects				
E307	external — minor	5	120.50	5
E308	— major	5	194.90	5
E310	— otoplasty for correction of outstanding ears — (patients under 18 years of age) — unilateral	5	148.80	5
Note:	E307, E308 — Descriptive details of procedure (eg: operative report) should be submitted with claims (see Surgical Preamble, paragraph (17)). E310 — this procedure is not a benefit of OHIP for patients 18 years of age or older.			
E314	Meatoplasty for atresia or stenosis of canal — congenital or acquired, with or without bone graft	5	141.70	5
E955	— with enlargement of bony canal and grafting of skin, add		141.70	1
E956	— with enlargement of canal, plus tympanoplasty, mastoidectomy and reconstruction of middle ear ossicles, add		258.60	2
MIDDLE EAR				
Introduction (I.O.P.)				
Eustachian				
Z910	Unilateral — local anaesthetic		4.25	
Z911	Unilateral or bilateral — general anaesthetic		24.80	4
U.V.C.	Insufflation of eustachian tube		visit fees	
Incision (I.O.P.)				
Myringotomy to include aspiration when indicated				
Z912	Local anaesthetic		11.70	
Z916	Local anaesthetic with insertion of ventilation tube using operating microscope		53.10	

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES

Code		Asst.	Surg.	Anaes.
			\$	
MIDDLE EAR - Cont'd				
Z913	General anaesthetic — with or without operating microscope, unilateral		28.30	4
Z914	— with insertion of ventilation tube using operating microscope, unilateral		53.10	4
Z915	Aspiration, for serous otitis		8.50	4
Excision				
Mastoidectomy				
E320	Cortical mastoidectomy, exclusive of any middle ear surgery	4	212.60	6
E322	Modified or radical mastoidectomy	4	340.10	7
E315	Revision mastoidectomy with revision of middle ear and regrafting	4	368.50	7
E959	— with meatoplasty and/or canal enlargement, add to E320, E322 or E315		67.30	
Repair				
E323	Myringoplasty		141.70	5
	Tympanoplasty — with middle ear and tympanic membrane surgery			
E336	— Type 1		212.60	7
E337	— Type 2, 3 or 4		304.70	7
E957	— with mastoidectomy, add		92.10	
E959	— with meatoplasty and/or canal enlargement, add . .		67.80	
E325	Facial nerve decompression	4	322.40	9
E326	Facial nerve graft	4	382.60	9
E327	Closure of mastoid fistula	4	170.10	4
E328	Exploratory tympanotomy		141.70	4
E329	Section tympanic plexus		251.55	6
E324	Tympanotomy with insertion of "permanent" ventilation tube		177.15	4
E316	Tympanotomy with round or oval window fistula repair .		177.15	6
INNER EAR				
Incision				
Labyrinthotomy or Labyrinthectomy				
E332	Surgical including Tack or Fick procedures or ultrasound		372.00	7
Repair				
E334	Stapes mobilization, unilateral		251.55	6
E335	Stapedectomy with prosthesis		372.00	6

October 1, 1982

Ontario Health Insurance Plan

Schedule of Benefits

LABORATORY MEDICINE



Ontario

Ministry of
Health



LABORATORY MEDICINE

Note: Claims for laboratory services, when referred by a Dentist, Osteopath, Chiropodist or Chiropractor are not insured services.

PREAMBLE:

1. The patient documentation and specimen handling benefit is applicable to all patients, except for those items listed under the anatomical pathology, histology and cytology sections. The items in this section have been left at a sufficient level to cover administrative costs. This benefit is not applicable to referred-in samples, since the collecting laboratory will already have claimed the patient documentation and specimen collection benefit.
2. The biochemistry section has been condensed so that one listing refers to a procedure for any of amniotic fluid (A), blood (B), C.S.F. (C), faeces (F), gastrointestinal fluid (G), urine (U). Exceptions are indicated by B, U, etc., following the test name. Other specimens will be considered on an I.C. basis.
3. A number of tests are listed in different sections of the schedule, i.e. when more than one method of performing the test is available, e.g. Aminophylline is listed under both Biochemistry and Radioassays. Assays of ligand type other than radioisotopic are listed under Biochemistry.
4. Blood glucose by the dipstick method may be claimed only when assessed by an appropriate instrument such as a reflectance meter. It should not be claimed when used only as a check on the fasting blood sample of a glucose tolerance test. The blood glucose of the fasting sample in a glucose tolerance test is allowable only once even if assessed by two methods.

Note: Glucose Tolerance Test is not listed in the Schedule. When requested the laboratory will comply with a standard 3-hour procedure consisting of 5 blood glucoses and 5 urinary sugar tests, unless specifically ordered otherwise (e.g. 5-Hour) and will bill for the number of each done if less.

5. Code L418 or L417 may not be claimed by a physician in addition to claim(s) for any treatment or assessment. However, Code G481 (see page 89 of the 1982 OHIP Schedule of Benefits) may be claimed by a physician if a haemoglobin screen (any method or instrument) is carried out in the course of an office or home visit. Urinalysis may be claimed with or without an associated visit to a physician's office (except for screening and urinalyses which are not medically necessary).
6. When a screening culture method (e.g. Agar spoon) is used on a urine sample, L641 refers to a culture technique and does not apply to those kits using the nitrite test only. Where a significant growth is obtained and followed up by definitive identification methods, L633 or L634 only should be claimed. The benefits for L633 and L634 include any necessary microscopic examination of the urine.
7. The Physician assumes responsibility for all cytology smears and the professional benefits (L804 to L815 inclusive) are weighted averages of the professional component. These benefits, therefore, are applicable in each case whether or not all slides are examined by the physician.
8. Only those tests which are requested are to be claimed with the following exceptions. It is intended that if the test results yield abnormal findings or information which would be in-

LABORATORY MEDICINE

complete, insufficient or meaningless to the referring physician, the medical director of a laboratory may add further appropriate tests and claim for them with the knowledge he may have to substantiate their justification.

9. A test must be completed in accordance with the pertinent Schedule listing in order to charge for it. The verbatim listing is intended as the definitive benefit for that test alone, unless otherwise specified e.g. isoenzymes do not include total enzyme estimations: creatine does include creatinine (as specified). Notwithstanding the foregoing and recognizing that it is impossible to list all variations in techniques of all listed tests, when there is a modification of the usual technique, the listing most closely approximating it should be used.
10. This schedule, with the exception of L036, lists actual procedures performed. No claim shall be made for calculated values made and reported, or for control tests or repeat tests on the same patient sample.
11. The benefit for seminal fluid examination (complete) is to include sperm count, volume estimation, motility and morphology and viscosity. The benefit for seminal fluid examination carried out post-vasectomy is not to be claimed by the operating surgeon unless the patient requires more than one office visit post-operatively.
12. Creatinine is a justifiable addition in the case of tests on 24-hour urine samples, where it is necessary to assess the sample as a complete 24-hour collection. However, if several tests (e.g. steroids) are done on a single such sample, only one creatinine should be claimed for that sample. In those estimations where the test result is expressed in terms of creatinine excretion (i.e. a certain quantity per mg. of creatinine) the performance of a creatinine is mandatory and may be claimed).
13. It is recognized that in requests for a serologic titre, if a screening test is used and would suffice, the lesser benefit for the screening test should be claimed. If positive and followed by a serial titration, both the screening and titre fees may be claimed. If the titration is a micro technique using plates, it is the equivalent of a tube titre, the wells being miniature tubes.
14. When a test for trichomonas identification (any method) is carried out in association with L625 or L627, code L653 may be claimed in addition. L653 also may be claimed when Wet Preparation is used for direct examination of a fresh specimen for vegetative amoebae or similar parasites. However, the wet preparation used in the faeces concentration technique for parasites and ova is included in L650.
The conditions set down in paragraph 8 of this preamble must be adhered to.
15. It is recognized that in all laboratory tests there is a professional component.
16. The maximum number of units which may be claimed for any combination of L418 (Hemoglobin), L417 (Hematocrit); L399 (WBC Count) and L397 (RBC Count) is 11 LMS units per patient per day, whether automated, semi-automated or manual methods are used. L700 is not included in this total and may be claimed separately, if appropriate. Laboratories using multichannel equipment should use individual codes as described above.
17. The maximum number of units which may be claimed for any combination of the tests represented by the following codes will be 40 LMS units per patient per day:

L005

L061

L194

L223

L252

LABORATORY MEDICINE

L030	L067	L204	L225
L045	L111	L208	L226
L053	L191	L222	L251

This maximum of 40 units applies on a per patient basis, regardless of the number of specimens submitted and regardless of the number of laboratories involved in performing the individual tests. Code L700 is not included in this maximum and should be claimed separately, if appropriate.

18. The maximum number of units which may be claimed for any combination of chemical analyses performed on a single sample by means of an automated chemical analyzer with simultaneously functioning channels is 18 LMS units (L225).
19. The definitions and guidelines in this paragraph apply to the Blood Bank section of Laboratory Medicine:
 - (a) L471 Antibody Identification — incomplete antibodies. A panel of any number of cells regardless of suspending media or technique used. Preparation of eluate and/or antibody absorption is included.
 - (b) L472 Antibody Identification — complete antibodies. A panel of any number of cells for the identification of complete antibodies by direct agglutination.
 - (c) L473 Parallel Titration — to be used when two sequential patient serum specimens are tested to detect a change in antibody titre. Includes a repeat antibody identification on the current sample.
 - (d) L490 Blood Group — ABO and Rh₀(D). The subgroups of A and RhD^u are included where indicated. A direct AHGT is also included in L490, therefore, L495 may not be charged on the same patient when this code is claimed.
 - (e) L492 Crossmatch. When an initial crossmatch is requested the appropriate claim is for L490 x 1, L482 x 1 plus L492 for each unit ordered. L490 and L482 may not be claimed more than once on the same day of service. L490 and L493 may not be claimed when these procedures are carried out as a confirmatory test on the units of blood to be transfused.
 - (f) L493. This listing includes L490 (see (d), above) and Rh genotype to include the antigens C, D, E, c, e, and D^u when indicated. Any other antigen is to be claimed under L494.
 - (g) L494 Blood Group per antigen. Antigens stated in L493 and L490 are excluded from this listing.
 - (h) L495 Direct AHGT. This listing may be claimed when ordered as a single procedure or in addition to L482 when the latter is requested as a single procedure. L495 may not be claimed when L490 or L493 is claimed with L482 on the same patient on the same visit.
20. Antibiotic sensitivities should not be done routinely, but only when, by reason of its identification and/or its concentration, the isolated organism has a high probability of being pathogenic.
21. The use of Nickersons Medium as a screening test for yeast is not a benefit.
22. The carcinoembryonic antigen test (CEA) L690 is not to be used as a general cancer screen. It is to be used only for following established malignancies.
23. This preamble is intended to apply to everyone using codes L700 and L001 to L724 and codes L800 to L829.

LABORATORY

L.M.S. UNITS	O.H.I.P. FEE	L.M.S. UNITS	O.H.I.P. FEE
	\$		\$
1	0.45	41	18.45
2	0.90	42	18.90
3	1.35	43	19.35
4	1.80	44	19.80
5	2.25	45	20.25
6	2.70	46	20.70
7	3.15	47	21.15
8	3.60	48	21.60
9	4.05	49	22.05
10	4.50	50	22.50
11	4.95	51	22.95
12	5.40	52	23.40
13	5.85	53	23.85
14	6.30	54	24.30
15	6.75	55	24.75
16	7.20	56	25.20
17	7.65	57	25.65
18	8.10	58	26.10
19	8.55	59	26.55
20	9.00	60	27.00
21	9.45	61	27.45
22	9.90	62	27.90
23	10.35	63	28.35
24	10.80	64	28.80
25	11.25	65	29.25
26	11.70	66	29.70
27	12.15	67	30.15
28	12.60	68	30.60
29	13.05	69	31.05
30	13.50	70	31.50
31	13.95	71	31.95
32	14.40	72	32.40
33	14.85	73	32.85
34	15.30	74	33.30
35	15.75	75	33.75
36	16.20	76	34.20
37	16.65	77	34.65
38	17.10	78	35.10
39	17.55	79	35.55
40	18.00	80	36.00

LABORATORY MEDICINE

24. The benefits for patient documentation and specimen collection and each test are calculated by multiplying the individual L.M.S. Unit values by .45¢.
25. Laboratory tests on specimens sent outside Ontario are not a benefit of the Plan.
26. Effective January 1, 1983, Reference Laboratories receiving specimens for additional (secondary) tests from another Laboratory that normally would be claimed as L319 or L500 should be claimed as L919 or L900 respectively.

Code	LMS Units
L700	7
PATIENT DOCUMENTATION AND SPECIMEN COLLECTION BENEFIT	

L700 may only be claimed with an "L" code other than L701 to L724 and L800 to L829.

1. Limited to 1 per patient, per day.
2. Not allowed to the recipient of a referred sample from another laboratory.
3. Not allowed to the attending physician.
4. Not refundable (in whole or part) to the referring physician or referring laboratory by the laboratory performing the test(s).
5. Not applicable to a patient visit solely to receive instructions or collection containers.
6. When multiple tests are ordered for the same patient for the same day, only one L700 may be claimed even though all specimens may not be available on any one day.
7. Not applicable to items under anatomical pathology, histology and cytology section.
(Fee Codes L701 to L724 inclusive).

BIOCHEMISTRY

(Applicable to all specimens except as denoted by B-blood, U-urine, F-feces, C-CSF, A-amniotic fluid).

L059	Acetaminophen	25
L001	Acetone, Qualitative (Ketones dipstick)	3
L002	Acetone, Quantitative	35
L003	Addis count — U	32
L004	Albumin, Qualitative	3
L005	Albumin, Quantitative (excluded if globulin and/or protein electrophoresis done)	10
L006	Alcohol, Ethyl-Quantitative	43
L007	Alcohols, Qualitative	25
L008	Alcohols, Fractionation and Quantification	45
L009	Aldolase	30

LABORATORY MEDICINE

Code		LMS Units
L010	Aldosterone	120
L011	Amino Acids — one way chromatography — B. U	15
L012	Amino Acids — two way chromatography — U	30
L013	Amino Acids, Fractionation and Quantitation	200
L014	Amino Acid Nitrogen	33
L071	Aminoglycosides (e.g. gentamicin, tobramycin)	40
L020	Aminophylline, Quantitative (theophylline)	40
L015	Ammonia	39
L016	Amniotic Fluid Scan	20
L017	Amniotic Fluid L/S Ratio	50
L018	Amylase	22
L021	Androstenedione	75
L019	Ascorbic Acid	25
L025	Barbiturates, Qualitative	25
L026	Barbiturates, Quantitative	35
L027	Barbiturates, Fractionation and Quantification	60
L028	Bile Microscopy	4
L029	Bilirubin, Qualitative — F	3
L030	Bilirubin, total	10
L031	Bilirubin, conjugated	10
	Blood gasses (see listings on pg. L10)	
L037	Blood Volume — excluding injection of dye	20
L038	Bromides	15
L039	Bromosulphthalein (BSP) excluding injection of dye	14
L045	Calcium	10
L046	Calcium Ionized	20
L047	Calculus analysis — chemical, Qualitative	15
L048	Calculus analysis, Qualitative and Quantitative	25
L073	Cannabinoid	35
L040	Carbamazepine, Quantitative	35
L049	Carotene	16
L050	Catecholamines, total	60
L051	Catecholamines, fractionated	80
L052	Ceruloplasmin	19
L041	Chlordiazepoxide, Quantitative	40
L053	Chloride	6
L054	Chloride (sweat)	33
L055	Cholesterol, total — not to be charged with L156	14
L056	Cholesterol, ester — not to be charged with L156	14
L057	Cholinesterase — pseudo or true	30
L058	Cholinesterase Genotyping (includes Pseudo, Dibucaine and Fluoride)	50
L060	Carboxyhemoglobin	15

LABORATORY MEDICINE

Code		LMS Units
L061	CO ₂ Content, CO ₂ Combining Power, Bicarbonate (measured, not calculated)	6
L062	Chymotrypsin	22
L063	Copper	40
L064	Cortisol	35
L065	Creatine (includes creatinine)	26
L066	Creatine Phosphokinase	25
L070	Creatine Phosphokinase, fractionation	34
L067	Creatinine (not with L068)	6
L068	Creatinine Clearance	15
L075	Crystal Identification (X ray powder diffraction analysis)	30
L069	Cystine Screening — U	8
L074	Diazepam, Quantitative	40
L072	Digoxin	45
L077	Diphenylhydantoin, Quantitative (phenytoin)	35
L076	Disopyramide	35
L078	Drug Screening, thin layer chromatography	20
L079	Drug Screening TLC + gas liquid chromatography confirmation	75
L085	Electrophoresis, serum — including total protein	36
L086	Electrophoresis, other than serum — including total protein	50
L080	Electrophoresis, serum — alone	26
L087	Estradiol	75
L088	Estriol — B	75
L089	Estriol, Pregnancy — U	50
L090	Estrogens, total — U	50
L091	Estrone	75
L092	Ethosuximide, Quantitative	35
L095	Fat, total — F	72
L096	Fat, Differential — F	92
L097	Fat and/or meat fibres (microscopic) — F	6
L098	Fat (microscopic) — U	6
L099	Fatty Acids, free	25
L094	Flurazepam, Quantitative	40
L100	F.S.H. (Pituitary Gonadotrophins)	60
L105	Galactose (per sample)	16
L106	Galactose-1-phosphate uridyl transferase (quantitative)	65
L113	Galactose-1-phosphate uridyl transferase (screening)	10
L107	Gamma glutamyl transpeptidase	15
L109	Gastric analysis titration (per sample)	7
L110	Globulin (excluded if albumin and/or protein electrophoresis done)	10
L111	Glucose, quantitative (not by dipstick)	6
L112	Glucose, semi-quantitative (dipstick if read with reflectance meter)	3
L114	Glutathione	20

LABORATORY MEDICINE

Code		LMS Units
L115	Glycoproteins	60
L093	Glycosylated hemoglobin — Hgb A ₁	22
L116	Gold	40
L120	Haptoglobin	15
L119	Hexoseaminidase A	15
L121	5H1AA Screening — U	9
L122	5H1AA Quantitation — U	50
L117	High Density Lipoprotein Cholesterol	18
L118	Histamine	90
L123	Homogenistic Acid (Qualitative)	9
L101	Homovanillic Acid, HVA	60
L124	Hydroxy Butyrate Dehydrogenase	10
L125	17-Hydroxycorticosteroids — U	34
L126	17-Ketogenic Steroids — U	40
L127	17-Ketosteroids, total — U	34
L128	17-Ketosteroids, fractionated — U	80
L129	Hydroxyproline — B	25
L130	Hydroxyproline, Total — U	90
L131	Hydroxyproline, Total and Free — U	150
L135	Inulin Clearance Test	40
L136	Insulin	40
L142	Intestinal Enzymes — qualitative	6
L143	— quantitative	22
L137	Iodine Protein Bound (P.B.I.)	21
L139	Iron, Total — with iron binding capacity	34
L141	Iso-Citric Dehydrogenase	15
L145	Lactic Acid (lactate)	27
L146	Lactic Dehydrogenase (L.D.H.), total	10
L147	Lactic Dehydrogenase Fractionation	29
L148	Lead	40
L149	Leucine Aminopectidase	15
L159	Lidocaine	35
L150	Lipase	22
L151	Lipid (total)	16
L152	Lipids (Thin Layer Chromatography)	30
L153	Lipoprotein, Electrophoresis-not to be charged with L156	34
L154	Lipoprotein, Ultracentrifugation	50
L155	Lipoprotein Lipase (Frederickson)	100
L156	Lipoprotein phenotyping (includes sample appearance, cholesterol, triglycerides, lipoprotein, electrophoresis and interpretation) — not to be charged with L055, L153 or L243	69
L157	Lithium	10
L158	Luteinizing Hormone (LH), chemical (not immunologic)	60
L165	Magnesium	13
L166	Malic Dehydrogenase	15

LABORATORY MEDICINE

Code		LMS Units
L167	Melanin — U	10
L168	Mercury	30
L169	Metanephrines, total — U	75
L170	Metanephrines, fractionated — U	90
L163	Methadone	15
L171	Methemalbumin	21
L172	Methemoglobin	21
L160	Methotrexate (amethopterin)	35
L175	Methylphenidate, quantitative	40
L164	Morphine	15
L173	Mucopolysaccharides — U	25
L174	Myoglobin, Qualitative — U	30
L161	N — acetylprocainamide	35
L180	5'-Nucleotidase	25
L181	Occult blood	3
L182	Ornithine Carbonyl Transferase	15
L183	Osmolality (osmolarity)	10
L185	P.A.H. Clearance	40
L081	Phenobarbitone	35
L032	pCO ₂	8
L033	pO ₂ (arterial)	8
L034	pH	7
L035	pCO ₂ , pO ₂ and pH in combination	17
L036	pCO ₂ , pO ₂ , pH-calculation of one or more of standard bicarbonate, base excess, etc.	3
L187	Phenothiazines, Qualitative — U	6
L188	Phenothiazines, Quantitative — U	30
L189	Phenylalanine	15
L190	Phosphatase, Acid	15
Note:	L190 — no additional claim may be made for a repeat test using an inhibitor (such as for prostatic acid phosphatase determination).	
L191	Phosphatase, Alkaline	10
L192	Phosphatase, Alkaline fractionation	29
L193	Phospholipids	30
L194	Phosphorus (inorganic phosphate)	10
L195	Plasma Clearing Factor (Baker)	35
L196	Plasma Hemoglobin	15
L197	Porphobilinogen (PBG), screen — U	10
L198	Porphobilinogen (PBG), Quantitative — U	25
L199	Delta-aminolevulinic Acid (ALA), Quantitative — U	25
L200	Porphyrins, screen	10
L201	Porphyrins, Quantitation (copro, proto, uro) — U	60
L202	Porphyrins, Quantitation (copro, proto, uro) — B	75
L203	Porphyrins, Quantitation (copro, proto, uro) — F	90
L204	Potassium	6

LABORATORY MEDICINE

Code		LMS Units
L205	Pregnanediol — U	70
L206	Pregnanetriol — U	80
L211	Primidone, Quantitative	35
L212	Procainamide	35
L207	Progesterone	50
L214	Propoxyphene	35
L213	Propranolol	35
L208	Protein, total — not to be charged with L085 or L086	10
L209	PSP (Phenolsulphonphthalein)	15
L210	Pyruvic Acid (pyruvate)	27
L215	Quinidine	18
L216	Reducing substances, identified by chromatography	30
L220	Salicylate, Qualitative	5
L221	Salicylate, Quantitative	12
L222	SGOT (AST)	10
L223	SGTP (ALT)	10
L225	Automated chemical analyzers with simultaneously functioning channels (single sample) — see Laboratory Preamble, paragraphs 17, 18	18
L226	Sodium	6
L227	Spectroscopic examination (any)	20
L228	Sulphemoglobin	21
L229	Sulphonamides	27
L230	T-4, Total (Thyroxine)	24
L240	Thiocyanates	15
L242	Thyroxine — Binding Globulin	50
L243	Triglycerides — not to be charged with L156	21
L244	Trypsin	22
L250	Urea Clearance	15
L251	Urea Nitrogen (B.U.N.)	6
L252	Uric Acid	6
L253	Urinalysis, routine (includes microscopic examination of centrifuged specimen plus any or all of S.G., pH, protein, sugar, hemoglobin, ketones, urobilinogen, bilirubin)	7
L254	Urinalysis, microscopy alone or one or more parts of L253 without microscopy (may not be claimed with urine culture for the same specimen)	3
L267	Urobilin, Qualitative — U	7
L255	Urobilinogen, Qualitative (not by dipstick) — U	7
L256	Urobilinogen, Quantitative — U	15
L257	Valproic Acid	35
L260	Vitamin A	30
L261	VMA (Vanilmandelic Acid)	60
L265	Xylose Absorption Test (per specimen)	6
L266	Zinc	25

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Code		LMS Units
L299	Biochemical assays not included above	I.C.
Note:	Biochemical assays other than specifically listed are not a benefit as such until approved by OHIP.	
	RADIO ASSAYS — The following codes apply only if an isotope is used. If alternate non-isotopic biologic, immunologic or chemical method is used, use different code under the appropriate section.	
L307	ACTH (Adrenocorticotrophic Hormone)	120
L300	Aldosterone	120
L691	Alphafetoprotein	45
L304	Aminoglycosides	40
L321	Aminophylline (Theophylline)	40
L305	Androstenedione	75
L322	Anti-DNA	45
L323	Anti-RNA	45
L301	Calcitonin	120
L302	C — AMP (Cyclic Adenosine Monophosphate)	60
L690	Carcinoembryonic antigen (CEA) (see Laboratory Preamble, paragraph 22)	I.C.
L346	C-peptide Immunoreactivity	60
L303	Cortisol	35
L347	Dehydroepiandrosteredione	75
L306	Digoxin	45
L324	Diphenylhydantoin (Phenytoin), quantitative	35
L310	Estradiol	75
L311	Estriol	75
L312	Estrogens — total — U	50
L313	Estrone	75
L329	Ferritin	45
L308	Folate, serum (not to be billed in addition to L309.)	45
L309	Folate, in red cells, to include serum folate and hematocrit ...	98
L315	FSH (Pituitary Gonadotrophins)	60
L316	Gastrin	75
L317	Growth Hormone	40
L318	HCG (Human Chorionic Gonadotrophins)	50
L319	Hepatitis associated antigen or antibody radioimmunoassay (e.g. hepatitis B surface antigen or antibody, hepatitis B anticore antibody, hepatitis A antibody) — per assay	45
L919	Hepatitis associated antigen or antibody radio-immunoassay by secondary laboratory per assay	45
L693	Hormone receptors for carcinoma (to include estrogen and/or progesterone assays)	I.C.
L320	HPL (Human Placental Lactogen)	50

LABORATORY MEDICINE

Code		LMS Units
L334	IgE	45
L688	Immune complexes by C1q binding	60
L689	Immune complexes by Raji cell assay	100
L325	Insulin	40
L326	Insulin antibodies	80
L327	Iron binding capacity	24
L328	LH (Luteinizing Hormone)	60
L330	Parathyroid Hormone	120
L343	Phenobarbitone	35
L348	Proinsulin radioimmunoassay	500
L331	Progesterone	50
L333	17-OH Progesterone	60
L332	Prolactin	75
L335	Renin	75
L336	T-3, Total (Triiodothyronine)	40
L337	T-3 Uptake	18
L338	T-4, Total (Thyroxine)	24
L339	T-4, Free — Absolute (includes T-4 total)	50
L340	Testosterone	50
L341	TSH (Thyroid Stimulating Hormone)	50
L342	Thyroxine Binding Globulin (T.B.G.)	50
L345	Vitamin B12	45
L524	Lymphocyte activation (transformation) by Isotope incorporation (limited to 3 mitogens and/or antigens)	200
L585	Radio-Immuno Assays (not included above)	I.C.
Note:	Radio-immuno assays other than specifically listed are not a benefit as such until approved by OHIP.	

HEMATOLOGY

L370	Assay of Factors II, V, VII, VIII, IX, X, XI and XII (each) ...	55
L371	Autohemolysis test	24
L372	Blood film examination (to include differential, red cell morphology and platelet estimate)	10
L374	Blood film — buffy coat preparation — not to be charged with L430	18
L375	Blood film — special stain	11
L376	Bleeding time — Duke method	8
L377	Bleeding time — Ivy method	15
L378	Bone marrow — film preparation	15
L379	Bone marrow — staining (Romanowski and iron)	23
L385	Capillary fragility	7
L386	Circulating anticoagulant	10
L387	Clot observation for lysis	7
L388	Clot lysis, dilute whole blood	10

LABORATORY MEDICINE

Code		LMS Units
L389	Clot retraction	6
L390	Clotting time (Lee and White)	8
L391	C.S.F. cell count (to include differential)	18
L395	Eosinophil count	8
L396	Platelet count	10
L397	R.B.C. count, excluding manual method (see preamble)	4
L398	Reticulocyte count	13
L399	W.B.C. count	4
L400	Euglobulin clot lysis	20
L401	Fibrinogen, semi-quantitative	6
L402	Fibrinogen, quantitative	28
L403	Factor XIII (Urea solubility test)	5
L404	Fibrinolysis (plate method)	16
L405	Fibrin split products, quantitative	30
L406	Fibrin split products, latex screening	5
L407	Folate, serum	45
L408	Folate, in red cells, to include serum folate and hematocrit	98
L410	G-6-PD screen	10
L411	G-6-PD quantitative assay	65
L412	Pyruvate kinase quantitative assay	65
L415	Haptoglobin	15
L416	Heinz bodies	15
L417	Hematocrit	3
L418	Hemoglobin	4
L419	Hemoglobin electrophoresis to include Hb A ₂ fraction	34
L420	Hemoglobin, fetal	20
L421	Hemoglobin, unstable	6
L422	Hemolysins — Ham's Acid Serum test	18
L423	Hemolysins — cold (Donath-Landsteiner)	18
L424	Hemosiderin in urine	11
L430	L.E. Cell prep — not to be charged with L374	18
L431	Kleihauer stain	18
L432	Malaria smear or other parasites	15
L435	Plasmapheresis	50
L436	Platelet function — aggregation, per additive	12
L437	Platelet function — adhesiveness	25
L438	Platelet function — thromboplastic function (PF-3)	28
L439	Preparation of cryoprecipitate (per treatment)	17
L440	platelet concentrates (per treatment)	25
L441	washed red cells	35
L442	leukocyte-poor blood	20
L443	Protamine titration	15
L444	Protamine sulphate test	10
L445	Prothrombin time	8
L446	Prothrombin consumption	10
L450	Osmotic fragility	45

LABORATORY MEDICINE

Code		LMS Units
L447	Reptilase time	10
L451	Sedimentation rate	4
L452	Sickle cell preparation	14
L453	Sickle cell solubility test (screen)	5
L454	Sucrose hemolysis	18
L460	Thrombin time	10
L461	Thromboplastin generation test	71
L462	Partial thromboplastin time	10
L465	Vitamin B ₁₂ , microbiologic, not isotopic	45

BLOOD BANK

	(Refer to Laboratory Medicine Preamble, paragraph 19.)	
L482	Antibody screening	16
	Antibody identification	
L471	— incomplete antibody (to be claimed only if L482 is positive or doubtful)	45
L472	— complete antibody (to be claimed only if L482 is positive or doubtful)	30
L481	Antibody titre per antibody regardless of method used (to be claimed only if either L471 or L472 yielded positive identification. Not to be claimed routinely.)	15
L473	Parallel titration on two specimens to include confirmation of previously detected antibody (see also OHIP Bulletin #4141)	75
L490	Blood group — ABO and Rh ₀ (D)	13
L492	— crossmatch per unit of blood	10
L493	Blood group — ABO and Rh genotype	40
L494	Blood group per antigen	8
L495	Direct anti-human globulin test	4

IMMUNOLOGY

	Single Gel Diffusion; Nephelometric Quantitative Assays	
L550	Immunoglobulin A, IgD, IgG, IgM	12
	Complement proteins	
L560	Titre — C _{1q}	12
L551	— C ₃ (B ₁ C)	12
L552	— C ₄ (B ₁ E)	12
L557	— C ₅	12
L558	— C ₃ proactivator	12
L561	— C ₁ -esterase inactivator	12

LABORATORY MEDICINE

Code		LMS Units
	IMMUNOLOGY - Cont'd	
	Miscellaneous proteins	
L553	— Ceruloplasmin	12
L554	— Transferrin	12
L555	— Alpha-1-antitrypsin	12
L556	— Alpha-2-macroglobulin	12
	Immunoelectrophoresis	
L575	Maximum of 3 antisera per test serum (per antiserum used) ...	30
	— monoclonal gammopathy screen	
	— L chains	
	— H chains	
L576	Cryoglobulin characterization	30
	Double Gel Diffusion, Qualitative (Ouchterlony)	
L568	Antibodies to food antigens (milk, wheat proteins), or to fungal antigens (allergic alveolitis screening series) per antigen — maximum of 4 antisera per patient screen	5
L565	Alphafetoprotein screen	5
L567	C ₁ -esterase inactivator screen	5
L566	Immunoglobulins, L chains, H chains	5
	Miscellaneous Agglutination Reactions (e.g. Rheumatoid factor; antithyroid (thyroglobulin or microsomal); streptolysin screen)	
L500	Screen	6
L900	Screen by secondary Laboratory	6
L502	Serial tube, 4 or more antigens	30
L501	Titre-serial tube, single antigen	15
L595	Alphafetoprotein — screen	15
L596	Anti-sperm antibodies — screen	20
L597	— titre	40
L660	Cold agglutinins — screen	6
L661	— titre	15
L665	C-reactive protein	6
L655	Pregnancy test	6
L598	Pregnancy test titre	15
Note:	L598 should not be claimed routinely, and may be claimed only if L655 is positive and there are additional medical indications for the addition of the titre.	
	Cellular Assays	
L533	ATP depletion test	275
L532	Caffeine stimulation test	300
L520	Nitroblue Tetrazolium Test — screen for enzyme deficiency ..	30
L528	Antibody dependent cellular cytotoxicity	200
L529	Naturally occurring cell cytotoxicity	200

LABORATORY MEDICINE

Code	— Cont'd	LMS Units
L522	Leukocyte chemotactic activity	150
L521	Intracellular leukocyte bacterial killing capacity (Holmes Test) — per organism	100
L523	Leukocyte phagocytic capacity	40
L524	Lymphocyte activation (transformation) by isotope incorporation (limited to 3 mitogens and/or antigens)	200
L525	Lymphocyte surface immunoglobulins by immunofluorescence	200
L526	Lymphocyte T and B cell rosettes	200
L527	Mixed lymphocyte reaction	300
Complement-kinetic (activity) assays		
L530	Total haemolytic complement (CH50 non-kit)	50
L531	Complement components (activity assays)	60
Fluorescent Antibody Tests (Immunofluorescent Studies)		
Serum anti-tissue antibodies (per type of tissue section examined and per serum dilution used irrespective of number of antibodies identified, maximum of 4 slides per serum).		
L544	— anti-nuclear (may include anti nucleolar)	35
L535	— anti-mitochondrial — anti-thyroid — anti-adrenal	50
	— anti-smooth muscle — anti-parietal — anti-skin — anti-sperm	
L545	Protein Deposition in Tissues (per biopsy examined, any number of antisera, e.g. Immuno-globulin, complement component, fibrinogen and pathinogens, etc.)	75
Histocompatibility Testing		
L580	— Tissue typing	200
L581	— Cross match	50
L582	— Antibody screening (per panel of 15 antigens)	150
L583	— HLA27 typing	50
Microbial Immunology		
L659	Antistreptolysin O, 7-tube titrations or microtechnique	25
L662	Complement fixation — screen	20
L663	— titre, single antigen	30
L664	— multiple antigens	50
L667	Direct fluorescent antibody (not to be claimed with listings under Microbiology Cultures)	12
L682	— for each additional antibody, add	4

LABORATORY MEDICINE

Code	— Cont'd	LMS Units
L683	Indirect fluorescent antibody	15
L684	— for each additional antibody, add	5
L668	Heterophile antibodies — screen (slide or single tube) — with or without absorption	5
L670	— with absorption by guinea pig kidney and ox cells, multiple tube titre (Paul Bunnell)	30
Note:	Hepatitis associated antigen or antibody RIA (see L319 under Radio Assays)	
L658	Trichinella antibody	6
L679	Virus antibodies — ELISA technique or hemagglutination inhibition (Rubella)	30
L680	— neutralization test	40
L681	— sucrose gradient separation of IgM + inhibition test	90
N.C.	VDRL	5
L503	Widal slide or tube agglutination	25
Radioimmunoassays		
(see listing under Radioassays)		
Miscellaneous		
L599	Cryofibrinogen — qualitative	5
L600	Cryoglobulins — qualitative	5
L601	Cryoglobulins — quantitative	30
L602	Pyroglobulins — qualitative	5
L604	Serum Viscosity — relative	10
L603	— quantitative	20
Modifiers		
(Units in addition to units for basic test where applicable — Immunologic procedures)		
L610	Concentration of sample before testing (any method)	2
L611	Radio-modification of standard technique utilizing isotope- labelled reagents	50
	— immunoelectrophoresis anti-Diphtheria;	
	— double diffusion anti-insulin	
	— radial diffusion anti-Tetanus	
Note:	Radio-modifications other than specifically listed under code L611 are not a benefit as such until approved by OHIP.	
N.C.	Preparation of special antigens or antisera	N.A.B.
N.C.	Special investigations	N.A.B.

MICROBIOLOGY

L620	Antibiotic level, serum	40
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LABORATORY MEDICINE

Code		LMS Units
	MICROBIOLOGY — Cont'd	
L621	Antibiotic sensitivity — per organism, max. of 2 per specimen (see Laboratory Preamble, paragraph 25)	9
L623	— M.I.C. — one antibiotic, tube or agar dilution	25
L615	Campylobacter culture in stool	3
L622	Chlamydia isolation	55
	Cultures (L667, L682 may not be claimed in addition)	
L624	— blood (including aerobic, anaerobic, subcultures, smears) per bottle	30
L625	— cervical, vaginal, including GC culture, Gram smear, yeast identification (e.g. Germ tube) not to be claimed with L627	25
L639	— fluids (CSF, joint, pleural etc. not exudates)	28
L626	— fungus, including KOH preparation and smear — not to be claimed for the same specimen with L625, L628, L629; includes L653 for fungus	20
L627	— GC culture and smear — not to be claimed with L625	20
L628	— other swabs or pus — culture and smear	25
L629	— sputum — culture and smear	22
L630	— stool, including necessary agglutinations	30
L640	— throat swabs, for streptococcus, screen only	6
N.C.	— screening for diptheria	N.A.B.
L631	— tuberculosis, including ZN or fluorescent smear	55
L632	— animal inoculation	100
L641	— Urine, screening, actual culture without identification — (see Laboratory Preamble, paragraph 6)	7
L633	— urine, pour plate or Miles-Misra quantitation	20
L634	— urine, calibrated loop quantitation	15
L642	Lysozyme inhibition test	13
L635	Pathogenic E coli (as sole procedure in infants only, such as fluorescent staining, not with L630)	5
L656	Penicillinase production	8
L636	Streptococcus grouping, Lancefield method	18
L638	Streptococcus grouping, coagglutination method	12
L637	Virus isolation	50
	Microscopy	
L645	Darkfield (spirochetes)	10
L646	Electron — direct, for viruses	40
L647	— immunoelectron microscopy	60
L648	— after ultracentrifugation	65
L649	— thin section, for virus	130
L650	Parasites and ova (faeces concentration)	18
L654	Parasites and ova, smear only, special stain	14
L651	Pinworm (Scotch tape prep)	5

LABORATORY MEDICINE

Code		LMS Units
	MICROBIOLOGY - Cont'd	
L643	Smear only, Gram or Papanicolaou stain, as sole procedure (not with L624-L634)	5
L652	Smear only, special stain, e.g. ZN, inclusions, spores, diphtheria	14
L653	Wet preparation (for fungus, trichomonas, parasites. See Laboratory Preamble, paragraph 14.)	3
	ANATOMICAL PATHOLOGY HISTOLOGY, AND CYTOLOGY	
Note:	Do not claim L700 in addition to codes L701 to L724 or L800 to L829.	
	The items listed in this section include only the technical component of the various items listed. The professional component for each item where applicable is listed in the following section.	
N.C.	Autopsy, gross and microscopic (including CNS as required) . N.A.B.	
	Chromosome Analysis	
L701	Chromosome banding	70
L702	Karyotype of blood or bone marrow	300
L703	Karyotype of skin or amnion cells	475
	Cytology and Histology	
L704	Amniotic fluid for fetal maturation	8
L705	Aspiration biopsy, (lung, breast, thyroid, etc.)	32
L706	Bronchial washings or brushings, per specimen	14
L707	Buccal or vaginal smear for Barr body	8
L708	Esophageal, gastric or endometrial washings or brushings	14
L709	Esophageal and gastric washings (including collection)	33
L710	Direct smears — oral, larynx, nipple discharge, vulva	13
L711	Fluids (pleural, ascitic, breast cyst, aspirate pericardial, CSF, urine and joint)	13
L712	Fluorescent Y chromosome	8
L713	Cervicovaginal specimen (including all types of cellular abnormality, assessment of flora and/or cytochemical evaluation)	13
Note:	For professional component use L812.	
L714	Smear for inclusion bodies	8
L715	Smear for eosinophils (nasal, sputum, ocular etc.)	3
L716	Sputum per specimen for general and/or specified assessment, (e.g., cellular abnormality, asbestos bodies, lipid, hemosiderin, etc.)	14
L717	Electron microscopy	225
	Metabolic bone study	
L723	— morphologic and morphometric assessment	250
L724	— kinetic assessment including fluorescent label studies ...	30

LABORATORY MEDICINE

Code	- Cont'd	LMS Units
L718	Seminal fluid examination (complete) — see Preamble	22
L719	Smear for spermatozoa only (post-operative) see Preamble	7
L720	Surgical pathology	16
L721	Operative consultation — with or without frozen section (up to three specimens)	15
L722	For each specimen over 3, add	8

ANATOMICAL PATHOLOGY, HISTOLOGY AND CYTOLOGY (Professional components only)

Note: "L" codes L800-L829 inclusive are professional interpretation benefits, they are not applicable to the taking of samples

Code		Professional Fee
N.C.		\$
	Autopsy, gross and micro (including CNS as required)	NAB
L800	Blood film interpretation	8.10
Z403	Bone marrow aspiration	21.10
L802	Bone marrow interpretation	28.70
L803	Chromosome analysis, per case	39.85
	Cytology	
L804	Amniotic fluid for estimation of fetal maturation	2.55
L805	Aspiration biopsy cytologic consultation (lung, breast, thyroid, etc.)	10.60
L806	Bronchial washings or brushings, per specimen	6.50
L807	Buccal or vaginal smear for Barr body	3.20
L808	Direct smears — oral, larynx, nipple discharge, vulva	2.80
L809	Esophageal, gastric or endometrial washings or brushings per complete specimen	6.50
L810	Fluids (pleural, ascitic, breast cyst, pericardial, CSF, urine and joint) per specimen	4.10
L811	Fluorescent Y Chromosome (peripheral blood)	4.10
L812	Cervicovaginal specimen (including all types of cellular abnormality, assessment of flora, and/or cyto hormonal evaluation)	2.80
	— For technical component, L713.	
L813	Smear for Inclusion bodies	4.10
L814	Smear for eosinophils (nasal, sputum, ocular, etc.)	1.20
L815	Sputum per specimen for general and/or specific assessment (e.g. cellular abnormalities, asbestos bodies, lipid, hemosiderin, etc.)	4.10
L816	Electron microscopy, per case	64.50
	Immunofluorescence Studies	
L817	Anti-tissue antibodies, per case	4.10

LABORATORY MEDICINE

Code	ANATOMICAL PATHOLOGY, HISTOLOGY AND CYTOLOGY - Cont'd	Professional Fee \$
L818	Protein deposition in tissues, per case	15.00
L819	Seminal fluid examination, complete (see Laboratory Medicine Schedule, Preamble, paragraph 11)	5.50
L820	Smear for spermatozoa only (see Laboratory Medicine Schedule, Preamble, paragraph 11)	2.55
L821	Surgical pathology, sections and report per case	15.00
L822	Operative consultation — with or without frozen section (up to three specimens)	30.80
L823	For each specimen over three, add	15.00
	Synovial fluid analysis	
L824	Description, viscosity and mucin clot	4.10
L825	Identification of crystals by compensated polarized light	8.30
L801	Metabolic bone studies	53.10
L827	Interpretation of carcinoembryonic antigen (CEA)	4.30
L828	Interpretation of RIA for hormone carcinoma receptors (to include estrogen and/or progesterone assays)	6.30
L829	Imprint and/or touch preparation (with or without special stains)	6.50

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(See also Table of Contents)

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